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# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

OTTAWA

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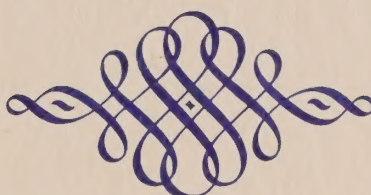
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1  
2 ROYAL COMMISSION ON HEALTH SERVICES

3  
4 Proceedings of the hearing held  
5 in Ottawa, Ontario, on the 23rd  
6 day of March, 1962.

7 COMMISSION MEMBERS:

8 Chief Justice EMMETT M. HALL -- Chairman

9 Miss ALICE GIRARD, R.N.

10 Dr. C.L. STRACHAN

11 Dr. ARTHUR F. VAN WART

12 Mr. M. WALLACE McCUTCHEON, Q.C.

13 Prof. O.J. FIRESTONE

14 Mr. DAVID M. BALTZAN

15 COMMISSION COUNSEL:

16 Mr. R.W. HALL, Q.C.

17 COMMISSION SECRETARY:

18 Mr. N. LAFRANCE  
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Ottawa, Ontario,  
Friday, 23rd  
March, 1962.

---On commencing at 10:00 a.m.

THE CHAIRMAN: Yes, Mr. Hall?

MR. HALL: Mr. Chairman and Members of the  
Commission: the next submission is that of the St.  
John Ambulance and the submission will be made by Dr.  
J.N.B. Crawford, the Chief Medical Advisor to the  
Order who will also introduce members of the  
organization to the Commission. I would suggest this be  
marked as Exhibit No. 202.

---EXHIBIT NO. 202: Submission of The St. John  
Ambulance.

SUBMISSION OF THE ST. JOHN  
AMBULANCE

APPEARANCES:

Dr. J.N.B. Crawford

Mr. A.E. Smith

Mrs. W.P. Warner

Miss M.J.L. MacLaren

DR. CRAWFORD: Mr. Chairman, and Members of  
the Commission: If I might first introduce my  
colleagues. On my right is Mr. Smith, Assistant  
Secretary of the Priory of the Order of St. John; Mrs.  
Warner, Chief Nursing Officer of the Order and Miss  
MacLaren, the Superintendent of St. John Ambulance  
Brigade.

As we understand it your task is to study  
the health needs and health resources of Canada. The  
Order of St. John which comprises St. John Ambulance  
Association and the St. John Ambulance Brigade is,







1 therefore, grateful for the opportunity to draw to  
2 the attention of the Commission the existence and  
3 activity of a voluntary organization which is  
4 dedicated to the teaching of the general public in  
5 areas which will enable them to play a supporting  
6 role to the professional health services of this  
7 country, particularly in the field of first aid and  
8 in home nursing.

9 The role and objectives, briefly stated,  
10 of the order of St. John is "encouragement and  
11 promotion of all works of humanity and charity for  
12 the relief of persons in sickness, distress, suffering  
13 and danger".

14 In carrying out this role the Order sponsors  
15 the St. John Ambulance Association which conducts  
16 classes in First Aid, Home Nursing, Child Care and  
17 related subjects for the general public. In addition  
18 the Order maintains the St. John Ambulance Brigade;  
19 an enrolled, uniformed body of men, women and young  
20 people trained in these subjects who carry out  
21 voluntary service in the community and are prepared  
22 for duty in times of emergency or disaster.

23 St. John Ambulance maintains a National  
24 Headquarters in Ottawa and Provincial Councils and  
25 offices in every province in Canada except Prince  
26 Edward Island. While Provincial Councils are autonomous  
27 in certain fields, overall direction and guidance  
28 stems from National Headquarters.

29 In addition Special Centres reporting  
30 directly to National Headquarters have been organized





1 in the Federal Civil Service and certain other groups  
2 such as the Department of National Defence, Bell  
3 Telephone, C.P.R. and C.N.R.

4 The St. John Ambulance Brigade which has a  
5 membership of approximately 9,500 is organized into  
6 Ambulance and Nursing Adult and Cadet Divisions with the  
7 necessary staffs to administer the Divisions.

8 The St. John Ambulance Association is  
9 responsible for the conduct of First Aid, Home Nursing  
10 and Child Care classes and is administered through the  
11 Provincial offices. First Aid instructors are trained  
12 by St. John. Home Nursing and Child Care instructors  
13 are registered nurses. Examinations are conducted by  
14 doctors and registered nurses. 528,600 individuals  
15 have qualified in these courses in the last five years.

16 The primary function of St. John Ambulance  
17 is in the field of health teaching and the preparation  
18 and service of volunteers in a supporting role to  
19 medical, nursing and the associated professional  
20 health services.

21 In First Aid classes, individuals are taught  
22 such basic care as may be afforded by a lay person  
23 pending medical treatment in order to save lives,  
24 lessen suffering and prevent further injury.

25 For selected candidates of Home Nursing in  
26 many cities, there are Hospital Experience courses  
27 arranged in cooperation with the Emergency Measures  
28 Organization that help give the layman an insight into  
29 hospital routine and the experience that can be  
30 invaluable in time of community need.







1           These courses in First Aid and Home Nursing  
2           in addition to providing education in health for the  
3           public at large, result in a pool of trained personnel  
4           who can be of great assistance in any serious emergency;  
5           at the scene of a disaster, in treatment centres, in  
6           hospitals or at home.

7           The St. John Ambulance has at present a  
8           consolidated annual budget of approximately \$800,000.  
9           The main sources of revenue are Community Chests,  
10          United and local appeals, municipal, provincial and  
11          federal grants, class fees and profits on sales of  
12          supplies. Expenditures include salaries, administrative,  
13          clerical, organizing, class expenses and expenses  
14          connected with the St. John Ambulance Brigade.

15          Each year for the past several years there  
16          has been a steady increase in the numbers trained by  
17          St. John.

18          There is great scope for improving and  
19          increasing the services already provided by St. John  
20          in the teaching and volunteer aspects of general  
21          health. These include the provision of services to  
22          suburban areas, isolated communities and the far north.

23          There are other areas of service such as the  
24          instruction of large numbers of the public in methods  
25          of resuscitation and rendering more First Aid at  
26          accidents on highways, where increased training and  
27          volunteer service could reap rich results.

28          The growth of population alone will result in  
29          an increased requirement for existing services.

30          While schools in certain provinces have First







1 Aid and Home Nursing on the curriculum, a widening of  
2 this practice would be a very beneficial program.

3 There is a tremendous amount of work to be  
4 accomplished in the training of individuals in First  
5 Aid, Home Nursing and Child Care in order that they  
6 may fit into existing and developing plans for Civil  
7 Defence and Survival Operations.

8 Industries are recognizing more and more the  
9 benefits to be derived from First Aid and Home Nursing  
10 training both from the point of view of treatment when  
11 accident or illnesses occur but also because of the  
12 preventive results obtained.

13 In any Home Care planning for Canada, the  
14 householder is an important factor. There is a real  
15 contribution to be made to the Home Care program by  
16 increasing courses of instruction in Home Nursing  
17 for lay people, to give the householder the preparation  
18 that will help her to carry on in the intervening time  
19 between the visits of the professional nurse, in  
20 addition to the "on the job" teaching of the visiting  
21 nurse.

## 22 Conclusion

23 St. John Ambulance is performing a most  
24 useful function among the lay public in supporting  
25 and augmenting the medical, nursing and associated  
26 professional health services in Canada. With an  
27 expanding population and the threat of nuclear  
28 emergencies the need for the services already provided  
29 and for additional related services continues to grow.  
30 St. John can meet this challenge only if it receives





1 continuing and increasing financial support from local,  
2 community and united appeals and from grants at  
3 municipal, provincial and federal level.

4 The St. John Ambulance, in its supporting  
5 role to professional health services, offers its full  
6 cooperation in measures that will ensure that the  
7 best possible health care is available to all  
8 Canadians.

9 The balance of the material before you  
10 provides a detail of what is done by the Order and how  
11 it is done. My colleagues with me, together with myself  
12 from National Headquarters will be very happy to try  
13 to answer any questions which you may have.

14 THE CHAIRMAN: Thank you, Dr. Crawford. You  
15 have no specific recommendations to make other than  
16 this one that you should continue to receive financial  
17 support from these various levels?

18 DR. CRAWFORD: That is so, sir. We are willing  
19 to help and we want to stay alive.

20 THE CHAIRMAN: Dr. Crawford, we are all  
21 familiar with the work of the St. John Ambulance if  
22 for no other reason than seeing you at the football  
23 games and sports arenas and so on where the Brigade is  
24 in evidence. How do you go about recruitment? You  
25 have a large body, 9,000 some odd.

26 DR. CRAWFORD: In the main it is a person  
27 to person advertising. We have quite a successful  
28 recruiting program among young people and we would  
29 hope that many of our Cadet corp people will remain  
30 with us in their adult years.







1 MR. SMITH: We do make a point of addressing  
2 the various classes and pointing out requirements that  
3 we have.

4 THE CHAIRMAN: Classes?

5 MR. SMITH: Classes in first aid where they  
6 are conducted and we make a point of someone addressing  
7 the people who have taken first aid training and  
8 requesting that they join the Brigade. That is  
9 from where the membership stems.

10 THE CHAIRMAN: Where do you get the classes  
11 in the first place?

12 DR. CRAWFORD: These are advertised in the  
13 paper that a class in first aid is being held. There  
14 is a good deal of person to person encouragement in  
15 this too. The first aid training is quite popular  
16 with the general public and we give notice that a  
17 class is being held, people are anxious to receive this  
18 type of training. This gives us, perhaps, a captive  
19 audience to try and bring into the Brigade.

20 THE CHAIRMAN: You do this through your own  
21 efforts?

22 DR. CRAWFORD: Yes.

23 THE CHAIRMAN: Dr. Baltzan?

24 COMMISSIONER BALTZAN: Brigadier and  
25 Associates, I want to pay you my very personal  
26 tribute for the work of the St. John Ambulance  
27 Association which apparently has come a long way from  
28 the days when I first heard of it. I see the field  
29 has been greatly extended. For the moment may I ask  
30 you to bring me up to date -- I am going to talk about







1 home nursing in this sense -- you now also carry on  
2 a program of continuing home care, is that one of the  
3 things you are doing at the present time?

4 DR. CRAWFORD: Yes sir. This, of course,  
5 falls on our home nursing training program and I will  
6 ask Mrs. Warner to speak to this. However, before  
7 that, I want to say that we feel that the training  
8 we give in home nursing enables the householder to  
9 provide pretty adequate care in their own home for  
10 anything less serious than the type of illness that  
11 needs hospitalization.

12 MRS. WARNER: We provide training for a  
13 convalescent person or a person with minor illness,  
14 how to care for an older person or a child in the  
15 home who does not need professional care or visiting  
16 professional care. It is simply basic care to turn  
17 them over and bathe them and feed them and get them  
18 up and moving them.

19 COMMISSIONER BALTZAN: Is this on a volunteer  
20 basis?

21 MRS. WARNER: Yes.

22 COMMISSIONER BALTZAN: Now, you have quite  
23 an extensive list and I did not know in my day that  
24 you needed so much but anyway you are doing such a  
25 great deal.

26 There is a number of full-time employees,  
27 clerical, etc. Your teachers and instructors only  
28 receive return for the expenses, they are not full-time  
29 paid teachers or are they?

30 DR. CRAWFORD: In general all our instructors





1 are volunteers who have qualified with us as  
2 instructors. That is, they have taken sort of  
3 advanced training in the things we are teaching. We  
4 do pay them a small fee for each class which they take,  
5 a very small fee, \$4.00, I think.

6 MR. SMITH: In some cases it is nothing,  
7 in some cases it is .50 cents per person, in some  
8 cases \$10.00 per class and a class is normally twenty  
9 or twenty-five persons.

10 COMMISSIONER BALTZAN: And these people  
11 give a lot of their time?

12 DR. CRAWFORD: Indeed they do.

13 COMMISSIONER BALTZAN: Disaster teams, do  
14 these people in uniform who go to various areas, do  
15 they receive remuneration or is it on a volunteer  
16 basis?

17 DR. CRAWFORD: It is on a voluntary basis,  
18 they even buy their own uniforms.

19 COMMISSIONER BALTZAN: Wonderful.

20 DR. CRAWFORD: They are out-of-pocket.

21 COMMISSIONER BALTZAN: One other thing to  
22 correct myself, I am thinking about something in the  
23 way of nomenclature, and I am very interested in  
24 this priory of the Order of St. John's of Jerusalem  
25 and England, would you explain that?

26 DR. CRAWFORD: Well, the Order is, of course,  
27 a very ancient order of chivalry which actually found  
28 its origin at the time of the Crusades. Actually  
29 they broke up into several national bodies and one  
30 was established in England. Now, it was originally







1 a clerical as well as a military organization and  
2 the governing body became known as a priory. . About  
3 1914 and 1915 a priory was established in Canada, so  
4 that although we owe a great deal to our parent body  
5 in England, the priory in England and indeed owe  
6 them allegiance, we are for all practical purposes of  
7 operation, autonomous in Canada. The Canadian  
8 operation is conducted by the prior of Canada which  
9 sponsors the Association and the Brigade and the  
10 activities of these off-shoots of the priory from  
11 Ottawa.

12 COMMISSIONER BALTZAN: I know much better  
13 where I stand now. Thank you very much.

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COMMISSIONER GIRARD: Mrs. Warner, on  
page 2, paragraph 9, there is a statement:

"For selected candidates of Home  
Nursing courses in many cities,  
there are hospital experience  
courses arranged in co-operation  
with the Emergency Measures Organi-  
zation that help give the layman  
an insight into hospital routine  
and the experience that can be  
invaluable in time of community  
need."

How many persons do you have doing  
this? Taking this experience in hospitals? I am aware  
that some is going on in Montreal. How extensive is it?

MRS. WARNER: Well, the third course  
is in operation now at the Ottawa Civic and about the  
seventh or eighth at the Toronto East General.

We had a course at Peterborough, Fort  
William. The third, at the Children's Hospital in Winni-  
peg. They had three in Saskatoon, three city hospitals  
in Saskatoon, Shaughnessy, and there is one that has just  
been completed at the Colonel Belcher and the Victoria  
Jubilee in Victoria. Moncton and St. John in New Bruns-  
wick. We haven't had any in Nova Scotia.

COMMISSIONER GIRARD: You have these  
courses, but how many are doing the actual experience  
in the hospital? The follow-up of these courses?

MRS. WARNER: I understand it is a  
selected group of eight to twelve.







1 COMMISSIONER GIRARD: And how prevalent  
2 how many are able to do this? Have this experience?

3 MRS. WARNER: We have already in 30  
4 hospitals about 100 people have had this experience in  
5 Red Cross and some of these are doing voluntary work in  
6 the same hospital one night a week. We have no idea of  
7 just how many that is, that we know.

8 COMMISSIONER GIRARD: What are the  
9 difficulties you experience in getting these persons to  
10 be able to enter the hospital to, in turn, share their  
11 experience?

12 MRS. WARNER: The difficulty with the  
13 hospital first was to bring in another group, another  
14 group of people. So many different groups now, so to  
15 overcome that Emergency Measures will have a supervisor  
16 take these eight to twelve people and supervise their  
17 procedures. They will first have orientation of the  
18 physical set-up of the hospital and then they will bath  
19 patients and feed them and other procedures of that kind.

20 COMMISSIONER GIRARD: So it was a  
21 question of having enough supervision to be able to  
22 supervise these extra persons on the wards? This was  
23 the difficulty, was it?

24 MRS. WARNER: Yes.

25 COMMISSIONER GIRARD: So you have been  
26 able to find a way to get the supervision. On page 3,  
27 paragraph 13, you say:

28 "There is great scope for improving  
29 and increasing the services already  
30 provided by St. John in the teaching





1 and volunteer aspects of general  
2 health. These include the provision  
3 of services to suburban areas, iso-  
4 lated communities and the far north."

5 Do you have any plan in respect of this  
6 kind of service or is it just a wish that you are expres-  
7 sing that this will come true?

8 DR. CRAWFORD: Perhaps Mrs. Warner,  
9 having a little bit of trouble.---

10 MRS. WARNER: I can tell you now. We  
11 have, in the far north, public health nurses who are excel-  
12 lent civil defence portable equipment, and then St.  
13 John has portable equipment that can be taken out to  
14 community halls, and schools, sometimes to aid the  
15 teaching.

16 We would like to have more of this  
17 equipment. It costs, to get this equipment and we  
18 would also like to have full-time nurses, at least one  
19 in every province who could arrange these courses and  
20 help these nurses who do the teaching voluntarily.

21 Our hope would be to be able to employ  
22 more nurses, to be able to provide more equipment and  
23 transport of this. We already have attempted in many  
24 areas, isolated areas, through the goodness and interest  
25 of perhaps married nurses there, or public health nurses  
26 in that area.

27 COMMISSIONER GIRARD: In how many  
28 provinces do you have at least one registered nurse  
29 working in connection with these courses?

30 MRS. WARNER: We have in five. Two of







1    them are paid and the others are volunteers.

2                   COMMISSIONER GIRARD:   In five provinces?

3                   MRS. WARNER:   Yes. There are nurses,  
4   volunteer nurses on what we call a Division but not for  
5   the whole province.

6                   COMMISSIONER GIRARD:   You would wish  
7   to have one in every province, I would imagine?

8                   MRS. WARNER:   Yes, very much.

9                   COMMISSIONER GIRARD:   I suppose I  
10   should not ask this: what is the obstacle?

11                   MRS. WARNER:   Financing.

12                   COMMISSIONER GIRARD:   I thought I knew  
13   the answer but I wanted you to say it.

14                   Paragraph 16 on the same page:

15                   "While schools in certain provinces  
16   have First Aid and Home Nursing on  
17   the curriculum, a widening of this  
18   practice would be a very beneficial  
19   program."

20                   I know that in some schools of nursing  
21   first aid in the curriculum is taught by St. John instruc-  
22   tors.   How prevalent is this?

23                   MRS. WARNER:   It was more prevalent in  
24   British Columbia, Quebec.   Quite a few they have now  
25   integrated first aid throughout the curriculum and  
26   teaching the burns and fractures and surgical nursing.

27                   COMMISSIONER GIRARD:   As they are  
28   teaching other subjects?

29                   MRS. WARNER:   Yes, rather than as a  
30   separate subject.





1 COMMISSIONER GIRARD: This has reduced  
2 the number of instructors, St. John qualified instructors  
3 to give this in the school?

4 MRS. WARNER: Yes.

5 COMMISSIONER GIRARD: Miss MacLaren,  
6 does the Brigade operate in every province?

7 MISS MacLAREN: It is in every province  
8 except Prince Edward Island. In Newfoundland.

9 COMMISSIONER GIRARD: Are there any  
10 plans - I think you have some plans for Prince Edward  
11 Island. I remember you speaking about them once. Do  
12 you have any idea whether you will be able to operate  
13 a Brigade in Prince Edward Island?

14 MISS MacLAREN: No, there are no plans  
15 at the present time but we review the situation from  
16 time to time. Naturally smaller territory we don't  
17 want to overlap with any other organization. We do feel  
18 there is a place there for the Brigade but there is  
19 nothing definite in mind at the present time.

20 COMMISSIONER GIRARD: Did you ever  
21 think of spreading to the Northern Territories?

22 MISS MacLAREN: We do in respect to the  
23 teaching program. It is pretty far to have an organized  
24 group as far away as that but one scheme that is working  
25 out quite well in the smaller and more remote areas,  
26 groups of people who have taken courses in first aid and  
27 home nursing were often organized as an auxiliary group  
28 which is not quite as formal as a Brigade Division and  
29 they are prepared to be of service in the community and  
30 they meet together from time to time to keep up their







1 skill and knowledge and that very often is the beginning  
2 of the more formal Brigade unit.

3 COMMISSIONER GIRARD: Miss MacLaren, I  
4 know one of your favourite projects, not just a project,  
5 an undertaking, was the Countess Mountbatten Fund.  
6 Would you like to speak about that?

7 MISS MacLAREN: This was a fund that  
8 was set up two years ago in memory of Countess Mount-  
9 batten of Burma, who was the Superintendent-in-Chief of  
10 St. John Ambulance Brigade in the Commonwealth and it  
11 was felt at that time perhaps the most appropriate form  
12 of contribution would be bursary assistance to nursing.

13 She was devoted to the advancement of  
14 nursing and we have set up this fund. This is being  
15 raised within St. John and among friends of St. John  
16 and so far we have given bursary assistance to seven  
17 nurses and we are looking forward to extending that  
18 assistance to additional nurses this year and it is a  
19 continuing project and it is growing and our intention  
20 is to be flexible and to try and meet the needs that  
21 are not being met by other sources.

22 COMMISSIONER GIRARD: Miss MacLaren,  
23 on behalf of the nurses I would like to thank you for  
24 that endeavour. Thank you very much.

25 COMMISSIONER STRACHAN: Can we hear  
26 more of the cadet group which you mentioned? What are  
27 their ages? Made up of male and female?

28 DR. CRAWFORD: I think perhaps Mr.  
29 Smith is better able than I to give you the details on  
30 age and so on.





1 MR. SMITH: I think perhaps Miss  
2 MacLaren is more versed in this.

3 MISS MacLAREN: Our cadet group is  
4 boys and girls. Their ages are 11 to 17. There is an  
5 intermediate group called Crusaders who may continue  
6 up to the age of 21. We have a few boy units. Most of  
7 our cadets are girls, and very often these are girls  
8 who are interested in possibly nursing as a career,  
9 a good many of them.

10 All community schools of nursing have  
11 carried out their program which includes first aid and  
12 home nursing and other subjects that make up for good  
13 citizenship and then they carry out a program of volun-  
14 teer service in the community to assist the adult members  
15 perhaps in first aid posts and some of them help in some  
16 of the older groups, go into perhaps children's wards in  
17 hospitals on a Saturday afternoon or helping with older  
18 people and generally helping in a variety of St. John  
19 services and it is our hope that as they grow up that  
20 they may later on go into the senior ranks.

21 COMMISSIONER STRACHAN: And if they go  
22 into training for nurses will they make better students?

23 MISS MacLAREN: We like to think they  
24 will. We think that very often it is that interest in  
25 taking home nursing and taking a certain amount of public  
26 service, in that field, that is just enough to make a  
27 girl decide that she wants to go into nursing.

28 COMMISSIONER STRACHAN: Does it some-  
29 times supply the incentive rather than the reverse? Is  
30 she encouraged to go into nursing through this course?







1 MISS MacLAREN: Yes, I think it might  
2 very easily, yes. We often make a point whenever we  
3 see these groups of saying "Hands up who wants to be a  
4 nurse". There is a great flourish of hands throughout  
5 the room.

6 COMMISSIONER STRACHAN: In the older  
7 group is there any age limit at all?

8 DR. CRAWFORD: No, the senior age  
9 limit - there is an official - 60, I think, 60 or 65.  
10 I must admit that this is probably more honoured in the  
11 breach than it is in the observation. We find that some  
12 of our most loyal supporters are perhaps beyond the  
13 official age limit.

14 COMMISSIONER STRACHAN: What is the  
15 normal length of course for a cadet and senior group?  
16 The hours?

17 DR. CRAWFORD: There are two courses  
18 really, one in first aid and one in home nursing. At  
19 the sort of basic level the first aid course is 13  
20 hours, 14 hours. In home nursing, 24 hours. Now, this  
21 may be spread out at the convenience of the class, of  
22 the instructor, concentrated in a couple of weeks or  
23 spread over months. The actual curriculum is 14 hours.





1           COMMISSIONER BALTZAN: Dr. Crawford, may  
2 I just ask one question that I had forgotten. Do any  
3 of your members officially attend the annual civil  
4 defence course?

5           DR. CRAWFORD: Yes, indeed, sir. We are  
6 deeply involved in the civil defence program,  
7 particularly as it is presented at Arnprior. As a  
8 matter of fact, I may say that Miss MacLaren is one  
9 of the very valued members of the Faculty at these  
10 courses; she does a great deal of teaching in the  
11 casualty simulation, melange, and that sort of work.  
12 We work very closely with the Civil Defence Organization,  
13 both in assisting to teach and presenting the courses  
14 and having our own people attend their courses.

15           COMMISSIONER BALTZAN: You would say that  
16 you are officially present, at least represented?

17           DR. CRAWFORD: At the Federal course, yes,  
18 we are very extensively.

19           THE CHAIRMAN: Dr. Crawford, as you will know,  
20 this Commission is hearing many suggestions that  
21 Canada should have one form of health service program  
22 or another and all the way from leaving things as they  
23 are to socialized medicine, as it is called. Is  
24 your organization, St. John Ambulance, concerned  
25 with the form of the plan or is it immaterial as to  
26 the form it takes to carry on your work?

27           DR. CRAWFORD: I don't think, sir, that  
28 whatever the outcome of your deliberations, it will  
29 lessen the need for voluntary efforts, and I think that  
30 voluntary effort works just as well under one system







1 of medical care as it will under another. I think we  
2 have proof of this. The Order of St. John is doing  
3 a very outstanding job in the United Kingdom where they  
4 have a form of medical coverage; it is doing a very  
5 good job in Canada where at the moment we have quite  
6 a different form. So I think we can work under any  
7 form of medical care so long as we retain our  
8 voluntary character. I think that the only time we  
9 get into trouble is if we began to pay people for what  
10 they did.

11 THE CHAIRMAN: You don't see any form of  
12 program as curtailing the need for the voluntary  
13 organization?

14 DR. CRAWFORD: I can't see that that would  
15 ever happen. I think that in any health plan that  
16 could possibly be envisaged there will be a need for  
17 voluntary effort on the part of people of goodwill.

18 THE CHAIRMAN: Thank you very much, Brigadier  
19 Crawford.

20 COMMISSIONER STRACHAN: In that connection,  
21 sir, I wonder if you feel that the response of the  
22 public to fund-raising would be affected?

23 DR. CRAWFORD: I don't think so in this  
24 connection, sir; I don't see why it should be. I think  
25 that people are not going to contribute to efforts  
26 which they think are going to be supplied from some  
27 other source, from state or insurance companies or  
28 anything else, they are not going to voluntarily  
29 contribute to such a program. But where there is  
30 no suggestion that there be any other form of support,





1 I think that people will continue to contribute quite  
2 happily.

3 COMMISSIONER STRACHAN: If they are informed  
4 of the facts they may feel that everything is going  
5 to be supplied, why should we contribute at all. I  
6 am thinking of the overall picture, not just pertaining  
7 to St. John Ambulance.

8 DR. CRAWFORD: Well, in the overall picture  
9 I wouldn't presume to comment, but with respect to our  
10 own operation, the people that we train probably have  
11 two incentives: one is the desire to be a help to  
12 their fellowmen, the other is the desire to learn  
13 something for themselves, they are getting something,  
14 and I think that many of them are prepared to contribute  
15 to a program which they feel enables them to look after  
16 their own family in emergencies; it is a value to them.

17 THE CHAIRMAN: That is speaking of the  
18 individual doing the work.

19 DR. CRAWFORD: Yes, and the general public.  
20 I think there are certain other organizations which  
21 have certainly found difficulties in what was once  
22 a voluntary or charitable service suddenly becoming an  
23 insured service. I am thinking of the blood service  
24 which is handled efficiently by the Red Cross; I think  
25 they are having more trouble now that blood service  
26 is an insured service.

27 COMMISSION STRACHAN: I am thinking of the  
28 fact that you now admit you would like more funds. Do  
29 you think under such a system as suggested by the  
30 Chairman that it would be more readily available?







1 DR. CRAWFORD: I think the welfare state  
2 will have to go an awful lot further than just the  
3 question of medical care before it would affect us.  
4 We have long been recognized as a charitable organization,  
5 and I don't think that people are going to stop giving  
6 just because their health needs, their doctors bills  
7 or their hospital bills are being met from some other  
8 source. I really don't feel that any scheme of  
9 health care will make our position more difficult.  
10 I think that we can continue to get public support  
11 for what we are doing, because obviously no health scheme  
12 is going to supply the sort of thing we do.

13 COMMISSIONER STRACHAN: I agree. I wonder  
14 what the public will think. I can quite appreciate the  
15 position of St. John Ambulance.

16 THE CHAIRMAN: Brigadier Crawford, Mr. Smith,  
17 Mrs. Warner, Miss MacLaren, we are very grateful for  
18 your presentation here this morning and for your  
19 views on the overall picture. We are very much  
20 interested in having the views of an organization such  
21 as yours which is voluntary in character, and I think  
22 I may say on behalf of all members of the Commission  
23 that as we have gone across Canada we have been impressed  
24 by the dedication of people in organizations, in  
25 voluntary organizations such as yours and the  
26 contribution they make to welfare and health service  
27 in Canada, and it is worthwhile to hear, whatever the  
28 future may hold, that your organization will carry on  
29 and can carry on.

30 DR. CRAWFORD: Thank you, sir. We are grateful





1 to you for hearing us.

2 MR. HALL: Mr. Chairman, the next submission  
3 is by the Canadian Anaesthetists' Society. The brief  
4 will be filed as Exhibit No. 203. The brief will be  
5 presented by Dr. Morton, who will also introduce  
6 the other members of the organization.

7 THE CHAIRMAN: Now, there is also a copy in  
8 French language which will be 203A.

9 MR. HALL: Yes, Mr. Chairman, Exhibit No. 203A.

10 ---EXHIBIT NO. 203: Brief of the Canadian  
11 Anaesthetists' Society.

12 ---EXHIBIT NO. 203A: Brief of the Canadian  
13 Anaesthetists' Society  
(French).

14 SUBMISSION OF THE CANADIAN ANAESTHETISTS'  
15 SOCIETY

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16 APPEARANCES:

17 Dr. M. Vivian Morton

18 Dr. Harold R. Griffith

19 Dr. R.G.B. Gilbert

20 Dr. R.A. Gordon

21 Dr. Leon Longtin

22 Dr. J.Blair Fulton

23 Dr. J.B.I. Sutherland

24 DR. MORTON: Mr. Chairman, I would like to  
25 introduce the members of the panel here, if I may.

26 This is Dr. J.B.I. Sutherland, Assistant  
27 Anaesthetist, Montreal General Hospital; Dr. Harold  
28 R. Griffith, Professor Emeritus, McGill University;  
29 Dr. R.G.B. Gilbert, Professor and Chairman of the  
30 Department of Anaesthesia, McGill University; Dr.







1 R.A. Gordon, Professor and Head, Department of  
2 Anaesthesia, University of Toronto; and on my left  
3 are Dr. Leon Longtin, Associate Professor of  
4 Anaesthesia, University of Montreal, and Dr. J. Blair  
5 Fulton, Anaesthetist, Vancouver General Hospital.

6 The attached submission of the Canadian  
7 Anaesthetists' Society undertakes to outline for the  
8 Royal Commission on Health Services the facts concerning  
9 anaesthetists and anaesthetic care in Canada. Our  
10 considered views on certain matters of importance to  
11 our specialty are forwarded.

12 The Canadian Anaesthetists' Society is the  
13 official voice of anaesthetists in Canada and we are  
14 proud to be able to present the story of a great  
15 growth in response to the challenges of medical progress  
16 and the demands of our fellow-citizens. Considering the  
17 size of our nation, Canadian anaesthesia has a vivid  
18 history and due to the intellect and devotion of its  
19 fathers has achieved a highly respected international  
20 stature.

21 Our efforts have provided for Canadians, not  
22 only high academic standards of care but a higher  
23 proportion of anaesthetists to apply these standards  
24 than any other nation in the world. It has readily  
25 reduced the hazard of all operative procedures and has  
26 enabled the performance of heart, lung and brain  
27 surgery which was previously impossible. It has an  
28 influence on the management of hospital facilities,  
29 providing an increasingly rapid recovery after operations  
30 and a more efficient use of beds. It has provided





1 techniques which are safe without expensive in-hospital  
2 care and enabled patients treated by minor surgical  
3 procedures to return to their homes on the same day.  
4 In order to provide a high order of anaesthetic care,  
5 the doctor must be willing to accept great responsibility,  
6 for the drugs which he uses to relieve his patient of  
7 pain are all dangerous ones and must be chosen and  
8 handled with minute-to-minute attention. Canadian  
9 medical practice has enabled us to shoulder this  
10 responsibility without allowing us to desert the  
11 individuality of a particular unconscious patient.

12 The following brief calls attention to the  
13 role played by our Society in the advancement of all  
14 facets of the specialty.

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1                   The formation of the organization was  
2 intended primarily to stimulate and provide for a high  
3 standard of post-graduate training in anaesthesia. In  
4 this aim it has achieved success. The organization of  
5 the Society into ten separate provincial divisions has  
6 enabled a notable effort in the field of continuing  
7 education to be effectively spread across the country.  
8 Our liaison with other agencies co-ordinate our activi-  
9 ties and provide representation where necessary. The  
10 growth of the Society has been spectacular and indicates  
11 its vitality. From 10 members in 1943, the membership  
12 has increased until in January 1962 it stood at 1,013.  
13 This increase is representative of the provision of new  
14 and qualified anaesthetists for Canadian patients. In  
15 spite of the voluntary nature of the organization, 90%  
16 of Canada's Certificated anaesthetists are members.

17                   The studies carried out by the Society  
18 confirm the view that, while such anaesthetists as we  
19 possess are reasonably well distributed, there is a  
20 shortage of trained personnel. We hold this view in  
21 spite of the fact that we have a higher proportion of  
22 anaesthetists than other comparable nations. We have  
23 welcomed a significant number of foreign-trained anaesthe-  
24 tists to Canada but we have also been training a very  
25 considerable number for other nations, including the  
26 United States. We will only continue to overtake the  
27 needs of this country if we are assured of sufficient  
28 graduates available for specialty training and a satis-  
29 factory climate of voluntary responsibility in which  
30 they may establish themselves.





1                    This Society supports any recommendations  
2   made in order to maintain and increase the supply of  
3   medical graduates of a high calibre. The subsidization  
4   of medical training following the patterns set by D.V.A.  
5   grants made after the War should be readily applicable.  
6   A period of "directed" service upon graduation would  
7   seem to us a reasonable requirement. However, we would  
8   prefer that an alternative be retained which would allow  
9   the graduate to repay any moneys if at any time it  
10   becomes possible for him to do so. We believe this  
11   problem should receive the most urgent consideration.

12                   Canadian Physicians interested in anaes-  
13   thesia have made important contributions which have had  
14   profound influence on the practice of surgery throughout  
15   the world. Up to the present almost all teaching and  
16   research in anaesthesia in Canada has been done in the  
17   so-called "spare time" of practising anaesthetists.  
18   Changes in methods of research and in the demands on  
19   teachers have made further progress along these lines  
20   increasingly impracticable. Provision must be made to  
21   provide remuneration for anaesthetists who spend a large  
22   proportion of their time in this work.

23                   In a field that is advancing as rapidly  
24   as ours, continuing education assumes a larger signifi-  
25   cance both for the Certificated and non-Certificated  
26   anaesthetists. The size of Canada and the distances by  
27   which we are separated put efforts of this kind at some  
28   disadvantage. Although our Society has a record of  
29   planning and achievement in this area of which we are  
30   proud, we would recommend consideration of grants to







1 teaching departments of Universities made specifically  
2 for this purpose. Small changes in the Income Tax Act  
3 would relieve to some extent the disadvantage at which  
4 the distant practitioner is placed.

5 In our brief we have pointed out that  
6 because of the nature of our work there may be some  
7 public misunderstanding of the role that we play, and  
8 for this reason we recommend that consideration be  
9 given to the establishment of a reliable source of infor-  
10 mation on matters of health and the sponsorship of a  
11 public programme of wide appeal. This we believe would  
12 serve the interests of both the public and the medical  
13 profession and have the effect of improving recruitment  
14 in medical schools.

15 There are certain things that we feel  
16 might be considered in order to make the best possible  
17 use of existing personnel. One of these is that we  
18 would recommend the increased provision of suitable out-  
19 patient facilities with adequate facilities for safe  
20 anaesthetic care.

21 In order to achieve greater efficiency  
22 in use of existing acute treatment beds, and the anaesthe-  
23 tic services associated with them, we recommend that  
24 emphasis be placed on the provision of suitable accommo-  
25 dation for these patients.

26 It is our professional opinion that  
27 modern transportation by adequately equipped and staffed  
28 vehicles is not detrimental to a patient's recovery.  
29 That in the consideration of the very nature of our  
30 country consideration be given to the provision of grants





1 for the setting-up of several pilot projects so that  
2 the utilization and costs of both road and air services  
3 could be studied.

4 This Society concerns itself chiefly  
5 with the maintenance of a high standard of anaesthetic  
6 care in Canada.

7 We recommend continuing support in  
8 principle of those means as are designed to aid in the  
9 provision of a high standard of care. These include  
10 the Medical Council of Canada, the specialty qualifica-  
11 tion programmes of the Royal College of Physicians and  
12 Surgeons of Canada, professional licensing powers and  
13 the Canadian Council on Hospital Accreditation. In  
14 addition, we support the promulgation of Hospital Stan-  
15 dards Acts which may include definition of the basic  
16 requirements for anaesthetizing areas and certain minimum  
17 requirements in respect to preoperative examination and  
18 the qualifications of attending personnel.

19 We recommend further application of a  
20 set of national standards and definitions in respect to  
21 such terms as a "surgical bed", a "long-stay case", etc.,  
22 which would enable organizations such as ours better to  
23 interpret data that is now available.

24 Mr. Chairman, our organization is a  
25 voluntary one. The submission that we present here  
26 has been considered in detail by the various provincial  
27 Divisions, as well as by our National Council, and we  
28 would thank you for accepting our submission.

29 THE CHAIRMAN: Thank you very much, Dr.  
30 Morton.







1 MR. HALL: Mr. Chairman, I believe that  
2 the Society wishes to make the submission in the French  
3 language also, and Dr. Longtin is prepared to do so.

4 THE CHAIRMAN: Dr. Longtin?

5 DR. LONGTIN: RÉSUMÉ ET SUGGESTIONS:

6 Le mémoire ci-joint de la Société Canadienne des Anesthé-  
7 sistes essaie d'exposer à la Commission Royale des  
8 Services de Santé les faits qui concernent les anesthé-  
9 sistes et les soins anesthésiques au Canada. Nous expri-  
10 mons nos opinions sur certains aspects importants de  
11 notre spécialité.

12 La Société Canadienne des Anesthésistes  
13 est le porte-parole officiel des anesthésistes du Canada  
14 et se sent fière de pouvoir raconter l'histoire d'un  
15 grand développement en réponse aux défis des progrès  
16 médicaux et à la demande de nos concitoyens. Si l'on  
17 tient compte des dimensions de notre nation, l'anesthésie  
18 canadienne possède une histoire bien vivante et grace à  
19 la clairvoyance et au travail de ses pères, elle a  
20 atteint un statut international des plus enviables.

21 Nos efforts ont procuré aux Canadiens  
22 non seulement des soins dont les standards académiques  
23 sont élevés mais aussi, pour appliquer ces standards,  
24 des anesthésistes proportionnellement plus nombreux qu'en  
25 aucun autre pays du monde. Cela a diminué considérable-  
26 ment le risque de toute opération et cela a rendu possible  
27 la réalisation, autrefois impossible, de la chirurgie du  
28 coeur, des poumons et du cerveau. Cela exerce une  
29 heureuse influence sur la gestion des soins hospitaliers  
30 en accélérant la convalescence post-opératoire et en





1 diminuant la durée d'hospitalisation. Cela a permis de  
2 mettre à point des techniques de toute sécurité permettant  
3 de pratiquer des opérations mineures sur des malades de  
4 l'exterieur qui retournent chez eux le même jour, sans  
5 avoir à defrayer des frais d'hospitalisation. Pour  
6 procurer des soins anesthésiques de haute qualité, le  
7 medecin doit consentir à prendre de grandes responsabili-  
8 tés, car les médicaments qu'il prescrit pour soulager la  
9 douleur sont tous dangereux et leur choix et leur mani-  
10 pulation exigent une attention de tous les instants.  
11 La pratique médicale canadienne, grâce à son organisa-  
12 tion, nous permet d'assumer cette responsabilité sans  
13 oublier la personnalité du malade inconscient.

14 Le mémoire ci-joint attire l'attention  
15 sur le rôle qu'a joué notre société dans l'avancement de  
16 la spécialité sous tous ses angles. La création de ce  
17 groupement, au tout début, visait à stimuler et à  
18 procurer un entraînement post-universitaire de haute  
19 qualité en anesthésie. Sous cet aspect, la société a  
20 remporté un franc succès. L'organisation de notre  
21 société en dix divisions provinciales a permis d'étendre  
22 à tous les coins du pays la réalisation de cette ambition.  
23 Nos contacts avec d'autres sociétés nous permettent de  
24 coordonner nos efforts et nos activités et, si nécessaire,  
25 de déléguer des représentants. La croissance de notre  
26 société a été spectaculaire et témoigne de sa vitalité.  
27 De 10 qu'il était en 1943, le nombre des membres atteig-  
28 nait, en janvier 1962, le chiffre de 1013. Cette augmen-  
29 tation donne une idée de la réserve d'anesthésistes  
30 jeunes et qualifiés au service des malades canadiens. En







1 dépit du caractère libre de cette organisation, 90% des  
2 anesthésistes certifiés du Canada font partie de la  
3 société.

4 A la suite d'études entreprises par  
5 notre société il appert que, malgré la distribution  
6 assez égale des anesthésistes que nous comptons, il  
7 existe un déficit de personnel qualifié. Nous mentionnons  
8 ce fait bien que, proportionnellement, le Canada compte  
9 plus d'anesthésistes qu'aucune autre nation. Nous avons  
10 accueilli de l'étranger un certain nombre d'anesthésistes  
11 qualifiés, mais nous avons préparé un nombre plus consi-  
12 dérable de sujets pour les autres nations, y compris les  
13 Etats-Unis. Nous allons continuer à combler les besoins  
14 de notre pays si nous avons un nombre suffisant de méde-  
15 cins qui se destinent a cette discipline et s'ils peuvent  
16 trouver une atmosphere propice au libre exercice de leur  
17 profession.

#### 18 FORMATION D'UN PERSONNEL BIEN ENTRAINE

19 1) Le nombre de gradués en medecine - Cette  
20 société seconde toutes les suggestions qui sont faites  
21 dans le but de conserver et, d'augmenter si possible, le  
22 nombre de gradués en medecine de haute qualité. Un  
23 système d'octrois pour l'étude de la médecine, semblable  
24 à celui que possédait le Département des affaires des  
25 vétérans après la guerre, devrait être mis sur pied  
26 immédiatement. Une condition raisonnable, à notre avis,  
27 serait d'exiger, après la graduation, une période de  
28 pratique surveillée our dirigée. Toutefois, il serait  
29 préférable de laisser au candidat qui a obtenu son  
30 diplôme la liberté de rembourser les sommes dues s'il





1 peut le faire. Nous croyons que ce problème mérite la  
2 plus urgente attention (Page 22, para. 43).

3 2) L'encouragement de l'enseignement et  
4 de la recherche - Les médecins Canadiens qui s'occupent  
5 d'anesthésie ont mis à point des nouveautés qui ont  
6 exercé une profonde influence sur la pratique de la  
7 chirurgie à travers le monde. Jusqu'à maintenant, au  
8 Canada, presque tout le travail d'enseignement et de  
9 recherche en anesthésie, a été fait au cours des préten-  
10 dus "temps libres" des anesthésistes en pratique. Les  
11 changements dans les méthodes de recherche et dans les  
12 demandes de professeurs ont empêché la réalisation de  
13 nouveaux progrès dans ces domaines. Il faut songer à  
14 remunerer les anesthésistes qui consacrent une grande  
15 partie de leur temps à ce travail (page 23, para. 44).

16 3) La poursuite de la formation - Dans un  
17 domaine comme le nôtre, où l'évolution est aussi rapide,  
18 le poursuite de la formation devient particulièrement  
19 importante tant pour l'anesthésiste certifié que pour  
20 le non-certifié. La superficie du Canada et les distances  
21 qui nous séparent réduisent l'efficacité de nos efforts.  
22 Bien que la société ait réussi à obvier à ces difficultés,  
23 nous suggérons fortement d'octroyer des fonds aux chaires  
24 d'enseignement des universités spécialement a cette fin.  
25 Des modifications mineures à la loi de l'impôt sur le  
26 revenu compenseraient jusqu'à un certain point pour les  
27 désavantages de ceux qui pratiquent à de grandes distances.  
28 (page 23, para. 45).

29 4) Education du public - Nous suggérons  
30 d'organiser un système de renseignements de source fiable







1 sur les questions de santé et de commanditer un programme  
2 public de grande envergure. Nous avons la conviction que  
3 cela servirait aussi bien les intérêts du public que  
4 ceux de la profession médicale et que cela pourrait  
5 améliorer le recrutement dans les écoles de médecine  
6 (page 24, para. 48).

7 UN MEILLEUR USAGE DU PERSONNEL EXISTANT

8 5) Organisation d'un plus grand nombre des  
9 cliniques externes bien outillées - Nous suggérons  
10 d'augmenter les fonds destinés à l'outillage des cliniques  
11 externes pour qu'il soit possible de procurer aux malades  
12 de l'extérieur des soins anesthésiques en toute sécurité  
13 (page 28, para. 56).

14 6) Des lits pour les chroniques - Pour  
15 améliorer le rendement des lits destinés aux traitements  
16 des maladies aiguës et aux soins anesthésiques qu'ils  
17 exigent, nous suggérons fortement de créer des locaux  
18 pour les malades chroniques (page 28, para. 56).

19 7) Services de transport - C'est notre  
20 opinion professionnelle que le transport moderne dans  
21 des véhicules bien outillés et par un personnel compétant  
22 ne nuit pas à la recouvrance des malades. Nous désirons  
23 attirer l'attention sur l'opportunité d'allouer des  
24 octrois pour l'organisation de projets type pour étudier  
25 l'utilisation et le coût possible de  
26 services routiers et aériens (page 25, para. 49).

27 MAINTIEN DE SOINS DE HAUTE QUALITE

28 8) Nous suggérons de continuer de supporter  
29 en principe les moyens décrits pour aider à procurer  
30 des soins de haute qualité. Sont inclus parmi eux: le  
conseil médical du Canada, les programmes du Collège





1 Royal des Médecins et Chirurgiens du Canada sur les  
2 qualifications des spécialités, les pouvoirs respon-  
3 sables des licences professionnelles et le conseil  
4 canadien sur l'accréditation des hôpitaux. De plus,  
5 nous endossons la promulgation de lois des standards  
6 hospitaliers qui peuvent inclure une définition des  
7 exigences de base pour les locaux servant à l'anesthésie  
8 et certaines exigences minima concernant l'examen pré-  
9 operatoire et les qualifications du personnel (page 23,  
10 para. 46).

11 9) Nous conseillons de plus la réalisation  
12 d'un formulaire de définitions et de standards nationaux  
13 en ce qui concerne des termes tels que "lits chirurgical",  
14 "cas d'hospitalisation prolongée", etc., ce qui permet-  
15 trait à des organisations comme la nôtre d'interpréter  
16 des données à notre disposition (page 24, para. 47).

17 THE CHAIRMAN: Merci, Dr. Longtin, pour  
18 votre memoire et les opinions sur votre société.

19 MR. HALL: Dr. Morton and her colleagues  
20 are prepared to answer any questions or enlarge on any  
21 part of the brief that the members of the Commission may  
22 wish to deal with.

23 THE CHAIRMAN: Perhaps to start, Dr.  
24 Morton, page 2 of the summary, the last phrase in the  
25 second paragraph there immediately above "Provision of  
26 Adequate Trained Personnel":

27 "We will only continue to overtake  
28 the needs of this country if we are  
29 assured of sufficient graduates  
30 available for specialty training







1 and a satisfactory climate of  
2 voluntary responsibility in which  
3 they may establish themselves."

4 What do you mean by that? The preface  
5 "We will only continue..." would accord it some importance.

6 DR. MORTON: Yes, Mr. Chairman. Well,  
7 it is our belief in our specialty, Mr. Chairman, that  
8 the responsibility, the challenge and the responsibility  
9 that is imposed upon the anaesthetist is one of the  
10 reasons that post-graduate medical students choose to  
11 become anaesthetists and they become better anaesthetists  
12 if they are people of this sort.

13 It is our belief our high standards  
14 depend, to a large extent, on the fact that these people  
15 have their free choice of going into this particular  
16 field and they welcome the responsibility placed on them  
17 and rise to this challenge.

18 THE CHAIRMAN: Is your reference that  
19 the voluntary aspect is entrance, in regard to the  
20 entrance to the specialty?

21 DR. MORTON: To some extent, yes.

22 THE CHAIRMAN: Well, in what other  
23 way?

24 DR. MORTON: I believe here that we  
25 were expressing a philosophical principle, in a way,  
26 that is possibly a little difficult to define in that  
27 the calls made upon any doctor and upon an anaesthetist  
28 still demand of him certain responses that are possibly  
29 not demanded of many other citizens.

30 He has got to accept these responsibilities





1 freely in a moral way as well as in any other  
2 way.

3 This sentence was not meant to do any-  
4 thing more than imply that we find the people who do  
5 volunteer take a voluntary interest in anaesthesia and  
6 are willing to devote their lives to it, make the best  
7 anaesthetists.

8 THE CHAIRMAN: I raise it because I  
9 have no recollection of hearing from any source any  
10 suggestion that physicians might be directed into any  
11 one specialty or away from any one specialty. Nobody  
12 has suggested that should not be made a completely volun-  
13 tary decision.

14 DR. MORTON: Oh yes, this was not  
15 intended to carry that implication.

16 THE CHAIRMAN: Or to erect a wall  
17 against the possibility of being suggested because, as  
18 I say, it has not been suggested. Then, page 4, para-  
19 graph 7, in the middle of the paragraph you set out the  
20 sentence:

21 "The principle of remuneration by  
22 a fee for each service given, being  
23 the most conducive to establishing  
24 a firm relationship between the  
25 patient and his doctor, is especially  
26 significant in the provision of  
27 anaesthetic care."

28 Then you go on:

29 "Taking the long-term view, this  
30 principle also is the only sure way







1 of acquainting these patients with  
2 the part played by anaesthetic care  
3 in their recovery ---"

4 Would you care to amplify? I put it  
5 this way: that much goodwill and, searching for reasons,  
6 I find it hard to accept that the basis of remuneration  
7 is really so important. I mean that it plays such a  
8 dominant part in the allegiance of the physician to the  
9 patient. I acknowledge and pay tribute to the allegiance  
10 of the physician to the patient but I am just wondering  
11 why you think that the manner of payment plays such an  
12 important part in it.

13 DR. MORTON: This is just part of a  
14 description, of course, Mr. Chairman, of the relationship  
15 of the anaesthetist to his patient. In considering this  
16 particular type of remuneration I suppose it is not  
17 unfair that we should compare it with other forms of  
18 remuneration.

19 The anaesthetist is in a different  
20 position to some other doctors; he undertakes, in most  
21 instances, to provide his patient with unconsciousness  
22 and there are ---

23 THE CHAIRMAN: I accept the extreme  
24 importance of the specialty and the very, very important  
25 function the anaesthetist plays in the health team.

26 The only point I am concerned with at  
27 the moment is why this method of payment loomed so large  
28 that you say that this principle is the only sure way.

29 DR. MORTON: Because at the moment in  
30 our nation this type of exchange is one of the tangibles





1 of our life. If a patient is responsible for remunera-  
2 ting the anaesthetist it seems to us he is more likely  
3 to understand what has been done for him. In the final  
4 analysis anaesthetic services or any other kind of  
5 services are only supported by an enlightened public  
6 and if you deny the direct relationship of the patient  
7 with his doctor, in this instance, his anaesthetist, then  
8 we have lost an opportunity to inform one more member  
9 of the public.

10 THE CHAIRMAN: Dr. Gordon, do you wish  
11 to add something?

12 DR. GORDON: I would like to say that  
13 the specialty of anaesthetics along with other special-  
14 ties has gone through a phase that a great number of  
15 specialties have gone through and human nature being  
16 what it is, and we find if you go day after day and  
17 month after month and are told he will turn up at a  
18 certain time, he will do a certain thing; when it comes  
19 to quitting time he says "Well, I am off now and Joe  
20 Blow is on call, let him look after it." We feel  
21 strongly and we have, as a matter of fact, had to go  
22 to some lengths to change this type of remuneration in  
23 order to raise the standards of practice.

24 Now, this, I do not think, is any  
25 reflection whatever on the care which the doctor gives  
26 to his patient. However, there comes certain personal  
27 pressures in a situation of this kind which persuade  
28 him that when his hours of duty are over his responsibility  
29 has ceased and someone else will take it on.

30 We feel this mitigates against good







practice and the best care of the patient.

1 THE CHAIRMAN: That is where you say the  
2 anaesthetist practices singly; as an employee?

3 DR. GORDON: As an employee.

4 THE CHAIRMAN: As an individual employee,  
5 not as one of a group that is providing the service to  
6 a hospital which I understand is becoming a pretty  
7 commonly accepted practice.

8 DR. GORDON: Commonly accepted on the basis  
9 of association of individuals in the same way where  
10 some employers associate themselves for business.

11 THE CHAIRMAN: I think probably with higher  
12 motives.

13 DR. GORDON: I think this is a very important  
14 factor the fact that an individual has this responsibility  
15 and it is reflected in his method of remuneration; in  
16 maintaining the best standard of practice.

17 THE CHAIRMAN: Dr. Gordon does your  
18 organization accept the principle of prepayment by  
19 voluntary organizations controlled by the medical  
20 profession?

21 DR. GORDON: I think that elsewhere in our  
22 brief sir we have stated that we subscribe to the  
23 views of the Canadian Medical Association in this  
24 respect.

25 THE CHAIRMAN: And that is their view, as I  
26 understand.

27 DR. GORDON: This of course does not destroy  
28 the principle of payment of a fee for the service  
29 rendered.

30 THE CHAIRMAN: I quite understand. Now do you





1 see any difference? Do you see any value in the  
2 patient personally paying the physician or the physician  
3 getting his cheque from a voluntary organization or  
4 from an insurance company?

5 DR. GORDON: Yes, I do.

6 THE CHAIRMAN: What?

7 DR. GORDON: If I may quote from personal  
8 experience sir, I have found the patient who carries  
9 the responsibility of paying the fees to his physician  
10 is more inclined to value his physician's services.  
11 This may be interpreted in one or two ways. It might  
12 be seized on as a suggestion from me that I want to  
13 be thought to be a good fellow in the circumstances.  
14 I do not mean it in this sense at all.

15 The patient who has some other personal  
16 organization paying the fee for the services which he  
17 receives from his physician without this relationship  
18 ever coming into the open between physician and the  
19 patient is less likely, I think, to value the service  
20 of his physician and he may do one of a number of things  
21 and there is statistical evidence on these points.

22 He may visit his physician and demand his  
23 attention on frivolous matters.

24 THE CHAIRMAN: I think, if you don't mind,  
25 it is probably not necessary to follow it through  
26 there because we are discussing what is a principle.  
27 We have heard that in Canada as a whole there is a  
28 considerable percentage of individuals who are covered  
29 by these voluntary organizations or by insurance  
30 companies.







1           When we come to the individual provinces  
2     like Ontario where the figure is said to be somewhere  
3     around 60 per cent, what I am having difficulty in  
4     following Dr. Gordon is that if the medical profession  
5     says that that is a good thing, how do you harmonize  
6     that with your suggestion that all that 60 per cent  
7     in Ontario which does not individually pay the  
8     physician, who have the bill paid, the patient has  
9     his bill paid for him by Ontario Medical, or whatever  
10    organization they belong to, perhaps Blue Cross at  
11    one time, how do you reconcile that with the views  
12    you are saying there is some magic over the patient  
13    handing the money to the physician?

14           DR. GORDON: I don't think I have quite said  
15    sir that there is some magic in the patient handing  
16    the money to the physician.

17           THE CHAIRMAN: Well some virtue.

18           DR. GORDON: Virtue. Each of these individuals  
19    while he may not at the moment when he is ill hand the  
20    money to the physician is overy much aware of the fact  
21    that every month or every quarter he is handing the  
22    money -- he feels, in fact, that if he is -- I have  
23    reached the stage where I must count to ten. May I  
24    answer your question by quoting a different situation?

25           THE CHAIRMAN: Yes.

26           DR. GORDON: This patient is in quite a  
27    different position. It is a different attitude to  
28    these physicians -- this is experienced in practice --  
29    when the individual who is -- we can quote Ontario  
30    again -- whose medical fees are being paid by the





1 workmen's Compensation Board.

2 THE CHAIRMAN: Why?

3 DR. GORDON: Why?

4 THE CHAIRMAN: Yes, why? Because workmen  
5 also contribute to that fund from which the physician  
6 is paid.

7 DR. GORDON: His employer.

8 THE CHAIRMAN: No, the workman too. Does  
9 he not?

10 DR. GORDON: No.

11 THE CHAIRMAN: Go ahead.

12 DR. GORDON: I think that is all I have to  
13 say on this point. I find that there is a great  
14 difference in the attitude of these patients. Some  
15 workman when he is being dealt with by his physician  
16 and he has paid his voluntary health insurance, when  
17 he appears for treatment and his medical care is  
18 being looked after by a third agency there is an  
19 entirely different relationship. I am afraid sir  
20 I cannot define this any further.

21 THE CHAIRMAN: Anyone else like to make an  
22 observation because you can appreciate just a plain  
23 layman who is only concerned with getting good medical  
24 service and perhaps might even be interested in  
25 getting it for nothing, perhaps we are entitled to  
26 express some concern with the method of payment which  
27 would have such an important bearing on the quality of  
28 service.

29 DR. GILBERT: Sir, it is a matter of  
30 philosophy of life, to a great extent. If you can get







1 something for nothing the standards do become lower,  
2 and if you even deny yourself a little something to  
3 procure the best there is established a relationship,  
4 in this case between the doctor and patient, which  
5 does not exist if the patient, per se, does not directly  
6 either pay or directly contribute out of his own  
7 pocket.

8 I know our experience certainly supports that.  
9 I don't know whether you wish to compare our status  
10 as it exists today with welfare states in operation at  
11 the moment. Rather a lengthy thing to do.

12 THE CHAIRMAN: Well I mean if it is of value,  
13 we are here to listen.

14 DR. GILBERT: You have only to look at the  
15 number of British trained anaesthetists and while I  
16 am answering this, don't think I left Britain because  
17 of that. I left Britain before the welfare state  
18 was organized but since it has been organized, a very  
19 large number of anaesthetists -- and I am not only  
20 speaking on behalf of the anaesthetists but other  
21 doctors have left Britain at the rate of 500 a year.

22 The values have changed, whether they are  
23 right or wrong. It's for you gentlemen to decide  
24 this philosophy. I know I can speak on behalf of  
25 our Society. We feel very strongly the status quo,  
26 with some modifications, is the one in which the  
27 general public, the Canadians at large will receive  
28 the best service and the best type of anaesthetists,  
29 the most dedicated kind of doctor.

30 DR. MORTON: Mr. Chairman apropos of your





1 difficulty with voluntary plans when they do undertake  
2 to actually carry out the exchange between the doctor  
3 and the patient and thereby remove this direct  
4 relationship that you feel that we advocate, I think  
5 we should add that in some ways these voluntary  
6 organizations have managed to preserve this in a way  
7 that some other forms of payment, not necessarily pre-  
8 payment, such as you said, the Workmen's Compensation  
9 Board have not been able to do and that this has been  
10 of great value to the patients.

11 We as anaesthetists have on occasion objected  
12 to some extent about this very thing within these  
13 organizations and of course the way they are set up,  
14 we are free to continue to do this as long as we  
15 adhere to this belief.

16 THE CHAIRMAN: You see, we had two distinguished  
17 gentlemen here yesterday afternoon with regard to the  
18 insurance position. They told us between the two  
19 companies they covered over one million Canadians with  
20 some form of prepaid position and other health service.  
21 Now the medical profession has no control at all as  
22 far as the insurance fraternity is concerned. Would  
23 you exclude that type of coverage from the prepaid  
24 plans that you would support ? That you would give  
25 support to?

26 DR. MORTON: I think the answer to that is  
27 no, Mr. Chairman. If this is the type of coverage  
28 that the patient feels is more suitable to him then  
29 I believe he should be free to choose that.

30 THE CHAIRMAN: But having chosen that method







1 of prepayment is this relationship with his physician  
2 going to be different than if he had chosen one of  
3 the doctors' voluntary plans? Or the quality of service  
4 that he is going to get or the dedication of the  
5 physician? I it going to be any less because the  
6 patient has voluntarily chosen this type of coverage,  
7 prepaid coverage as distinct from that type which is  
8 the medically sponsored type of coverage?

9 DR. MORTON: I think sir we should limit  
10 this to the place of the anaesthetist. I wouldn't want  
11 to have an opinion on any other type of medical practice.

12 THE CHAIRMAN: That is quite fair.

13 DR. MORTON: And I believe that in an  
14 individual case there would be no difference. I believe  
15 that we are talking about the development of this  
16 relationship. The way in which this is preserved.  
17 The way in which this is free to grow and the freedom  
18 that it gives the patient to seek financial relief,  
19 not talking about medical relief but financial relief  
20 in every way he feels suits himself best.

21  
22 -

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1 DR. GORDON: Mr. Chairman, might I just  
2 mention a point here. I think, if I may, that your  
3 remarks concerning the insurance industry bring up  
4 a point which must be defined. The type of coverage  
5 which you have suggested is the same as fire insurance,  
6 a money contract, an indemnity plan, which is a matter  
7 of the insured contracting with an insurance company  
8 and in a certain eventuality he will receive a certain  
9 amount of money which has no relationship to the  
10 financial relationship between the patient and the  
11 physician, and this must be distinguished quite clearly  
12 from the voluntary plans which are sponsored by the  
13 profession in which the medical profession does have  
14 some voice and which we distinguish from the  
15 indemnity or fire insurance type of coverage by  
16 voluntary service plans. I think since this question  
17 has been asked that we must make this quite clear  
18 that you can insure against falling down stairs or  
19 being hit by a red streetcar or a green streetcar.  
20 It is in the same class.

21 THE CHAIRMAN: Accepting that -- and it is  
22 in great measure true from what we have heard -- but  
23 accepting it, the way you put it, does the patient  
24 who insures under one of these insurance plans that  
25 you have described and who pays the physician and  
26 who expects to pay the physician with money from  
27 the insurance company, is his relationship with his  
28 physician or anaesthetist any different or is the  
29 service he gets any different than the patient who  
30 is covered by the Ontario Medical?







1 DR. GILBERT: I think, sir, we have to look  
2 twenty-five years ahead, but I think if we are going  
3 to change -- I unfortunately used the word "dedication"  
4 just now; you can't change dedication over night. I  
5 mean, one form of remuneration for the group of doctors  
6 here, our methods wouldn't change, but I think if  
7 methods of remuneration are going to be changed  
8 dramatically, then I think in twenty-five years'  
9 time we might see a change in the type of man practising  
10 the type of work.

11 THE CHAIRMAN: Now, I appreciate that, and I  
12 am not trying to argue for any one form of service  
13 as against another, I am just trying to understand  
14 what is involved in this insistence on the form of  
15 payment having such importance as medical men attribute  
16 to it.

17 DR. SUTHERLAND: Mr. Chairman, I think if  
18 we could go back just a little way. The genesis  
19 of the doctors' sponsored plans I think has something  
20 to do with the doctor's attitude towards his patient,  
21 and I think this development came about because in  
22 some areas doctors realized that some prepayment  
23 scheme is the only way in which patients could -- I  
24 don't think the term insured is quite correct -- it  
25 is the only way a patient can stand the unpredictable  
26 incidence of illness, and I think doctors are surely  
27 in the most critical position to feel badly if their  
28 patient becomes financially upset because of medical  
29 costs. Now, in this context and with this feeling  
30 I think that doctors are glad to see their patients





1 covered by whatever form of insurance they have. You  
2 spoke previously of a conflict between the idea that  
3 a patient has some prepaid form of insurance, and if  
4 there was a conflict between the method of payment --

5 THE CHAIRMAN: I have no recollection of urging  
6 that there was a conflict.

7 DR. SUTHERLAND: I thought you used that  
8 term, sir.

9 THE CHAIRMAN: I put the question to you, if  
10 in the way you are putting it forward, you are not  
11 suggesting a conflict.

12 DR. SUTHERLAND: I felt, sir, that you were  
13 suggesting something --

14 THE CHAIRMAN: If I did, I did not intend to  
15 do that.

16 DR. SUTHERLAND: Conflict between the doctor's  
17 wish to be paid on a fee for service basis.

18 THE CHAIRMAN: I suggested an inconsistency.

19 DR. SUTHERLAND: You suggested an inconsistency.  
20 That is the point I am leading up to.

21 THE CHAIRMAN: And inconsistency in the  
22 doctor's attitude.

23 DR. SUTHERLAND: But this is based on the idea  
24 that doctors support prepaid plans.

25 THE CHAIRMAN: Yes.

26 DR. SUTHERLAND: Doctors support prepaid plans  
27 because it helps their patients.

28 THE CHAIRMAN: You said doctors supported  
29 doctor-organized prepaid plans.

30 DR. SUTHERLAND: I said doctors are anxious to







1 see that their patients are covered, and I don't think  
2 it is fair to say that doctors are not anxious to see their  
3 patients covered by what are called commercial plans.  
4 I think doctors are happy to see their patients  
5 covered by any plans, and because doctors support  
6 doctor-sponsored plans doesn't mean they are opposed  
7 to other plans.

8 THE CHAIRMAN: Accepting that wholly, without  
9 reservation, doctor, so that there may be no basis  
10 for misunderstanding on the effect of my question,  
11 which I am going to repeat, does the physician in  
12 your organization see any difference between having  
13 the patient having his bill paid by a medically-sponsored  
14 prepayment plan or by one of these other insurance  
15 plans which you have said the doctors are also in  
16 favour of their patients having it?

17 DR. SUTHERLAND: I think I was getting on to  
18 a point, but I think the way you put the question, we  
19 are talking about --

20 THE CHAIRMAN: I would like you to deal with  
21 that question now. Perhaps we got off on the wrong foot.  
22 I want to break the question down, and I am not going  
23 to press it; if you don't want to deal with it we will  
24 drop and I won't be any better informed than I was  
25 before. If you want to leave me in that condition,  
26 that is your privilege.

27 DR. MORTON: Well, Mr. Chairman, I should  
28 perhaps comment here that our organization is not  
29 one that primarily concerns itself with this particular  
30 aspect. We are, of course, individually interested in







1 it. We are really here representing the anaesthetist  
2 on a different subject and it was possibly wrong of  
3 us to introduce this particular matter into the brief.  
4 But we were talking about it on the basis of principle,  
5 and what we as an organization believe from the history  
6 of anaesthesia in this country in the various  
7 relationships between various types of insurance.

8 THE CHAIRMAN: If you want to leave it that  
9 way, but you do say in your brief that it is the only  
10 sure way of accomplishing the objectives of the fine  
11 service that your organization hopes to render to the  
12 public of Canada in the days to come.

13 DR. MORTON: Yes. Well, sir, we do believe  
14 this, and I think it has perhaps a good deal to do  
15 with what relationship the patient may have made with  
16 organizations that interest themselves in financial  
17 matters. What we are very anxious to preserve and  
18 what we don't believe can be readily preserved under  
19 some forms of prepayment is this tremendous direct  
20 responsibility that we accept for every individual  
21 patient.

22 THE CHAIRMAN: We are not talking about that.  
23 I accept that, and there is no question of the  
24 competence and the dedication of your doctors to the  
25 patient. Having put the question in the two forms that  
26 I have put it, it naturally takes me to the third aspect  
27 of it. If there should be no difference between  
28 the patient handing the money over to the physician  
29 or the doctor-sponsored medical plan paying the bill  
30 for the patient or the insured's company providing the





1 money to the patient to pay the bill on the prepaid  
2 basis, what then is the essential difference if a  
3 governmental agency should provide the money to pay the  
4 bill?

5 DR. GILBERT: There is a little difference  
6 in the first part of the question. In an ordinary  
7 insurance plan the doctor has little to do with putting  
8 a value on his services; the patient has gained money --

9 THE CHAIRMAN: This was predicated on a fee  
10 for service basis.

11 DR. GILBERT: There are various -- the patient  
12 can insure himself on whatever terms he likes.

13 THE CHAIRMAN: Would you deal with the question  
14 on the basis I put it, if it is intelligible to you?

15 DR. GILBERT: The first portion of your  
16 question, sir, was aimed at differentiating, I believe,  
17 between the doctor-sponsored plan --

18 THE CHAIRMAN: My last question, doctor,  
19 would you please deal with it or not as you see fit,  
20 but please don't transpose. We have these three ways  
21 of payment: the patient handing over the \$5.00 bill  
22 to the physician or the \$20.00, whatever it may be;  
23 the doctor-sponsored plan doing the same thing for  
24 the patient, or the patient himself paying the doctor  
25 with the money he gets from the insurance company.  
26 If we accept all that as being not conducive to lowering  
27 the standard of medical care or violating the best  
28 principles of doctor-patient relationship, what  
29 difference then would there be if a governmental  
30 agency handed over the money for the patient?







1 DR. GORDON: The difference is not a matter  
2 of the \$20.00 bill.

3 THE CHAIRMAN: It is not who hands it over  
4 you say?

5 DR. GORDON: No, the difference is in the  
6 control. Now, if we may deal with these three  
7 situations which you posed in your question one at a  
8 time.

9 In the first place it is a straight horse  
10 trade between the patient and the insurance company,  
11 and has no relationship as to the cost of the medical  
12 service between patient and doctor. There is no  
13 suggestion that indemnity medical insurance covers  
14 the cost of medical care. It is a money contract.

15 In the second place, the doctor-sponsored plan  
16 is open to negotiation as to cost, and if medical care  
17 begins to cost more, and I am not necessarily talking  
18 about medical fees, the drugs and medical techniques  
19 and so on, the money will be found, because people who  
20 subscribe to the plan want the best medical care,  
21 and if it of necessity costs X dollars, this will be  
22 found in the way of increased payments by the consumer.

23 If a government-controlled agency does this  
24 it must be done on the basis of a budget. There is  
25 only so much money. I have seen this in operation  
26 in the Scandinavian countries. There is only so much  
27 money and if the new techniques cost X plus \$2.00,  
28 you cannot have it, because the \$2.00 is not available  
29 in the budget. That is the difference, and that is  
30 what the profession objects to.





1 THE CHAIRMAN: You think there would not  
2 be enough money to go around and take care properly  
3 of the physician service?

4 DR. GORDON: The control is in the wrong place,  
5 so that the increasing costs, which are part and parcel  
6 of medical progress, we have seen tremendous increases  
7 in medical costs in the past twenty years because of  
8 the development of new techniques. These things,  
9 if the money is not available, just do not become  
10 available to the patient.

11 THE CHAIRMAN: I don't wish to misquote you,  
12 but am I correctly interpreting what you said, that  
13 your objection is not to the manner of payment, but  
14 to the end result, that the end result is going to be  
15 bad?

16 DR. GORDON: In the context of your question,  
17 sir, as to what the difference would be.

18 THE CHAIRMAN: Yes, that was the question.

19 DR. GORDON: As a result then, we have a  
20 decline in progress, and we have a deterioration in  
21 medical practice.

22 THE CHAIRMAN: Because of the adoption of  
23 a governmental plan in any form?

24 DR. GORDON: Yes, which must be limited to  
25 a budget.

26 DR. GRIFFITH: The gist of the situation  
27 so far as this Society is concerned, I think, regarding  
28 methods of payment, is that we are not opposed, as  
29 these other members have said, to any method by which  
30 the patient pays, but we are interested in the fact







1 that the patient has some kind of a direct relationship  
2 with the doctor, and knows what kind of service he is  
3 getting, and one of the best ways in which that has  
4 been demonstrated is that the patient has some kind of  
5 financial responsibility for that. We only have to  
6 think about the rise, of not only the growth in size  
7 of this Society, but the way in which it has been  
8 outlined in this brief. There has been a tremendous  
9 change over recent years. Part of that is because  
10 we think the relationship between patient and doctor  
11 has been more satisfactory to all concerned, and we  
12 like this method of payment because it has worked  
13 pretty well for us. Just a few years ago in some  
14 of our larger hospitals an anaesthetist was a hospital  
15 employee, whose services were simply lumped in with  
16 the hospital bill, and there is no doubt that the  
17 change in that has been responsible for the provision  
18 of better anaesthesia for the patients.

19 THE CHAIRMAN: Dr. Longtin, est-ce-que vous  
20 avez quelquechoses à ajouter à ce sujet?

21 DR. LONGTIN: Si vous voulez Monsieur le  
22 Président, je peux le dire en Anglais.

23 THE CHAIRMAN: C'est très bien les autres  
24 qui sont avec vous pourront comprendre.

25 DR. LONGTIN: We had an argument, I don't  
26 know what value you will give to that argument. We  
27 have been for years doing business, I may say, with  
28 the patient, and that has improved, I would say, our  
29 standard, our quality of services, in two ways. First,  
30 on behalf of the patient, because the patient looks





1 after the service he is going to pay for, and the  
2 anaesthetist has to see the patient many times before  
3 putting him asleep, and he has to see him many times  
4 after, but the drugs we use sometimes with a few  
5 months delay may produce all kinds of, I would say  
6 side effects on memory or trauma on the arms, and so  
7 on, and if the doctor meets his patient after, when  
8 he comes to pay his bill he may, no doubt his  
9 attention will be drawn to trauma or complications of  
10 anaesthesia, and in that way he will improve his  
11 services in the future. On behalf of the doctor, if  
12 he is paid by a third party it is only human to say,  
13 well, I am supposed to do three or four visits to  
14 that patient, but I will be paid just the same if I  
15 do only two, and he may after a while give, I would say,  
16 a lesser quality of service to his patients, and I  
17 am feeling that the contact we have kept with the  
18 patients for the last twenty-five years has been a  
19 reason why we have attained so high quality of  
20 services compared with any other kind of payments.

21 COMMISSIONER FIRESTONE: I wonder, Mr. Chairman,  
22 if I could follow up the answer which Dr. Gordon gave  
23 you in reply to the question you raised about the end  
24 result on the Association of a government-sponsored  
25 scheme?

26 Dr. Gordon, am I correct that you felt that  
27 the quality of service which the anaesthetist gives might  
28 suffer if a government-sponsored scheme were introduced,  
29 and as I understood one of the reasons given by you  
30 was that governments would use a budgetary approach.







1 Did I understand that point correctly?

2 DR. GORDON: That is correct.

3 COMMISSIONER FIRESTONE: Well now, sir, how  
4 do you reconcile a reduction in quality with the oath  
5 which you take as physicians. Don't you take an oath  
6 to offer the best service that you can render to the  
7 patient?

8 DR. GORDON: I am not making any suggestion,  
9 Mr. Firestone, that the quality of the service which  
10 might be rendered by the individual physician with  
11 his two hands, his eyes, his ears, his brain, would  
12 change in any respect, but the professional man must  
13 have facilities and the tools to work with, and this  
14 is particularly true in the specialty of anaesthesia.  
15 He also must have a certain amount of leisure time in  
16 which to keep up with his profession, and for  
17 recreation, and our experience in visiting departments,  
18 important departments of anaesthesia in those parts  
19 of the world where the budgetary approach is applied  
20 by a government controlling health services, is that  
21 techniques which we now find are every day, and which  
22 are essential to provide the best possible service to  
23 the public of Canada, without which we couldn't do  
24 many of the things which we now do to correct serious  
25 disease, are just not available to these people, and  
26 when we ask them why, the answer is that the Ministry  
27 has not any money. We find departments in major  
28 hospitals covering a very large load of work, where  
29 no one has time to think, where everyone is exhausted,  
30 one asks at the Karolinska Hospital in Sweden, why for







1 1500 beds have you only six anaesthetists. The answer  
2 is the Ministry has no money to hire more. This is  
3 the way in which the service deteriorates. This is  
4 followed very quickly by a deficiency of personnel,  
5 because intelligent people will just not direct them-  
6 selves into that sort of career under those  
7 circumstances.

8 COMMISSIONER FIRESTONE: Dr. Gordon, if we  
9 can confine the discussion to the Canadian situation  
10 and to the anaesthetists only. If I understand you  
11 correctly, that you have no fear that even under a  
12 government-operated scheme that anaesthetists wouldn't  
13 give the best service they can, remembering the oath  
14 they have taken, that as far as they are concerned,  
15 with their two hands, their eyes, their ears, and  
16 their brains, they will provide the best service they  
17 can.

18 You referred to tools, and secondly to  
19 leisure. How are the tools of the anaesthetist  
20 provided now?

21 DR. GORDON: On the whole these are provided  
22 in two ways. They are privately provided by  
23 anaesthetist themselves, or they are provided through  
24 voluntary agencies. Some of them are provided  
25 through the hospitals. I might say, and I am  
26 anticipating your next question I think, that a good  
27 many of the tools which we require for our special  
28 procedures in the major hospitals in this country  
29 are provided through voluntary subscription and  
30 voluntary agencies. I think I will leave it at that





1 in order not to incriminate myself with --- I will  
2 leave it at that.

3 COMMISSIONER FIRESTONE: Let us assume,  
4 sir, that a government scheme were to develop which  
5 would take account of the two points you have made,  
6 to take account of the provision of adequate tools.  
7 We understand you need the tools to practice your  
8 profession, and also efforts to encourage more young  
9 people to take an interest, through inducement and  
10 other possibilities in this particular field and  
11 therefore, by increasing the supply there would be  
12 more leisure for those left in the profession. If  
13 these qualifications are taken care of through some  
14 scheme, how would you then feel about the role of  
15 the anaesthetist in a government-operated medical  
16 care plan?

17 DR. GORDON: I don't wish to appear facetious  
18 in my answer, but I wouldn't believe it would happen,  
19 and I have personal reasons for believing this. It  
20 is some many years since a situation arose where a  
21 technique which was widely accepted outside the  
22 government service recommended itself to me when I  
23 was employed in the government services and I applied  
24 to have the necessary drugs and equipment to put this  
25 into effect, and the reply was we have never heard of  
26 this, and we don't intend to buy it.

27 COMMISSIONER FIRESTONE: When did that take  
28 place?

29 DR. GORDON: Do I have to name the year,  
30 because now we are getting around to personalities.







1 COMMISSIONER FIRESTONE: Not particularly  
2 within one or two years. Was it twenty years ago?

3 DR. GORDON: Twenty-five years ago.

4 COMMISSIONER FIRESTONE: That is good enough  
5 sir. Now, let us assume, looking ahead to the next  
6 five years, there may be some advancement in thinking,  
7 both on the part of the medical profession and the  
8 government and the Canadian public. We can give  
9 credit that we have made some progress in the last  
10 twenty-five years. Have you any views on the subject,  
11 if these two qualifications were met by some reasonable  
12 scheme which doctors felt is as reasonable as one  
13 can expect --

14 THE CHAIRMAN: The doctor would consider it  
15 to be a miracle.

16 DR. GORDON: I think we have to be  
17 practical. I just don't believe that any such miracle  
18 is going to happen.

19 COMMISSIONER FIRESTONE Well, this is  
20 of course your own judgment, and there may be others  
21 who have different views on this point. All I want  
22 to know, if you have some views if these two  
23 qualifications could be met, whether you have the same  
24 objections to a government-sponsored scheme? The  
25 answer is yes, or no, or you have no views.

26 DR. GORDON: The answer is not yes or no.

27 COMMISSIONER FIRESTONE: Or you have no views?

28 DR. GORDON: It is, if I qualify that if I  
29 may. The answer to your question, if such a miracle  
30 should happen, would be yes.





pw

1 COMMISSIONER FIRESTONE: Please, I  
2 have not suggested there is a miracle, would you there-  
3 fore just deal with my question as I have put it.

4 DR. GORDON: That answer is ---

5 COMMISSIONER FIRESTONE: These contin-  
6 gencies are met or the qualifications which you have  
7 mentioned are met.

8 DR. GORDON: I suppose logically the  
9 answer would have to be yes but, as I said, I preface  
10 this with the statement that I would have to qualify  
11 this and I feel it would have to be made in such a way  
12 that the control of the decisions must be left in the  
13 hands of the medical profession.

14 COMMISSIONER FIRESTONE: Would you  
15 accept that if such arrangements are worked out in  
16 co-operation with the medical profession, because  
17 presumably a government that pays a large amount of  
18 money will want to have a say in the matter but if it  
19 could be worked out in co-operation --- ?

20 DR. GORDON: This was ---

21 COMMISSIONER FIRESTONE: I just want  
22 to have your answer.

23 DR. GORDON: I am willing to concede  
24 that.

25 COMMISSIONER FIRESTONE: The answer to  
26 the question is ---?

27 DR. GORDON: Yes.

28 COMMISSIONER FIRESTONE: I have one  
29 more question and I will address that to Dr. Morton,  
30 if I may.







1 In your recommendation 3 on the third  
2 page, you speak of:

3 "Small changes in the Income Tax Act  
4 would relieve to some extent the  
5 disadvantage at which the distant  
6 practitioner is placed."

7 You refer further to paragraph 45 on  
8 page 20 for elaboration.

9 The question, Dr. Morton, is: can the  
10 Association suggest any specific income tax changes  
11 that you would like to recommend in this connection?

12 DR. MORTON: Yes, it is my understanding  
13 that no allowance is made financially for a doctor to  
14 pursue this type of post-graduate study and this is in  
15 distinction, of course, as to his attendance at conven-  
16 tions and so on.

17 It would seem reasonable to us, in view  
18 of the fact we all acknowledge that a doctor needs to do  
19 this, to make it as easy as possible for him to do it  
20 would be the sensible thing for those in distant places.

21 If it is in a small place, and so on,  
22 he has to make arrangements for coverage while he is  
23 away and in many instances I am sure if this is made a  
24 little bit easier for him he would be much more likely  
25 to do it.

26 COMMISSIONER FIRESTONE: Is your recom-  
27 mendation that the expenses incurred by an anaesthetist  
28 who is taking up graduate studies should be deductible  
29 from his income?

30 DR. MORTON: At least some part of it.







1                   COMMISSIONER FIRESTONE: At least you  
2 are in favour of the principle. Could you tell us  
3 whether you are in favour of 100% or 50%? What is  
4 your recommendation?

5                   DR. MORTON: I do not think we would  
6 necessarily be prepared to make a specific recommendation.

7                   COMMISSIONER FIRESTONE: But you under-  
8 stand, Dr. Morton, that this is a Royal Commission  
9 designed to advise the Federal Government as to what  
10 should be done and unless we get recommendations from  
11 the people affected how are we to know what you want  
12 and what will be in your best interests?

13                   Therefore, if you cannot help us, how  
14 are we going to advise the Federal Government?

15                   DR. MORTON: You mention percentages.

16                   COMMISSIONER FIRESTONE: It was you,  
17 madam, that said "At least in part". If you had said  
18 "We are in favour of it" that would have closed the  
19 question but you said "At least in part" so I have to  
20 ask you what part.

21                   DR. MORTON: This expense included a  
22 number of things, and travel is one of them and certainly  
23 it is a part we would feel would need to be included  
24 because it is of the most benefit to the man who is  
25 furthest away.

26                   COMMISSIONER FIRESTONE: Those are the  
27 travelling expenses?

28                   DR. MORTON: Yes, travelling expenses.

29                   COMMISSIONER FIRESTONE: What about his  
30 fees at the place he is taking his graduate studies?





1 DR. MORTON: This could very well be  
2 included.

3 DR. GRIFFITH: I think we will say  
4 100% of his out-of-pocket expenses.

5 COMMISSIONER FIRESTONE: This was my  
6 question and I am quite satisfied if the answer is  
7 "yes". Once you say "in part" I have to figure out  
8 what you mean. Is the Association recommending that  
9 expenses incurred by anaesthetists who are taking up  
10 graduate studies be a deductible expense from the  
11 income? Is that the recommendation you are making?

12 DR. MORTON: Yes.

13 COMMISSIONER FIRESTONE: Thank you  
14 very much.

15 DR. SUTHERLAND: Could I add one word?

16 THE CHAIRMAN: Yes.

17 DR. SUTHERLAND: I think the provisions  
18 of the Income Tax Act do now provide some relief with  
19 regard to attendance at formal Association conventions  
20 for doctors just as they do for other people. The same  
21 provision specifically excluded attendance at refresher  
22 courses and I think this is one of the items in this  
23 particular recommendation which was envisaged. I think  
24 in this connection the simple way of stating one aspect  
25 of it would be to say that a physician who undertakes  
26 for his own betterment and for the safety of his own  
27 patients to attend refresher courses, that the out-of-  
28 pocket expenses just as they are in the shape of conven-  
29 tions, I think should be regarded in the same light as  
30 legitimate convention expenses. At the moment this is







1 not the gist of the law with regard to income tax  
2 deductions.

3 COMMISSIONER FIRESTONE: That is a very  
4 helpful comment, thank you very much.

5 COMMISSIONER BALTZAN: Dr. Morton, it  
6 is very nice indeed to see you as spokesman along with  
7 your male associates and I am sure our colleagues in  
8 the dental profession must be fairly envious.

9 I have a very few questions here. You  
10 apparently have made very great strides in increasing  
11 your number of recognized specialized anaesthetists;  
12 what would your answer be to a question about major  
13 operations, do you foresee in the future that all major  
14 operations would be conducted under the anaesthesia  
15 provided by a specialist in anaesthesiology?

16 DR. MORTON: Well, we are working  
17 towards this ideal, certainly, and it must be to a  
18 considerable extent true today.

19 We, unfortunately, although we investi-  
20 gated this, are unable to provide you with an estimate  
21 of what the situation actually is today. We would like  
22 to feel this is the ideal towards which we work but  
23 nobody as yet has achieved this. We cannot foresee how  
24 long it would take us to have it.

25 COMMISSIONER BALTZAN: That is what  
26 you are heading for ideally?

27 DR. MORTON: Yes, that is our ideal.

28 COMMISSIONER BALTZAN: In one of your  
29 tables you show that the ratio of anaesthesologists to  
30 population is better in Canada than the other two





1 countries referred to. Am I right in interpreting your  
2 figures?

3 DR. MORTON: Yes, that is right.

4 COMMISSIONER BALTZAN: And these two  
5 other countries have specific programs for patients  
6 that are existing?

7 DR. MORTON: That is indeed true and  
8 they have been in existence for some years, they are  
9 not new programs.

10 COMMISSIONER BALTZAN: You take that  
11 as significant apart from the fact we are better off  
12 with anaesthesologists in Canada, the fact that here  
13 the ratio is better than in other countries?

14 DR. MORTON: I believe it has some  
15 significance because academically speaking Great Britain  
16 has been in the forefront of anaesthetic advance and  
17 has contributed very greatly and even so they are expect-  
18 ing their anaesthetists to provide a service to the  
19 British people which, according to the standards that  
20 actually exist in Canada today, it is difficult to under-  
21 stand how they can do this.

22 COMMISSIONER BALTZAN: Thank you. My  
23 next question is, are young doctors, new graduates of  
24 medical schools today, who are heading for general practice,  
25 receiving inadequate training in anaesthesia for minor  
26 and sometimes even major surgery? How does the curricu-  
27 lum meet that need?

28 DR. MORTON: Well, there is a consi-  
29 derable variation across the country. I would say anaes-  
30 thesia is a thing that can really only be learned by







1 doing it and it will depend, to some extent, on the  
2 location of the particular graduate, how much provision  
3 they have been able to make for this. It certainly  
4 does vary widely, I believe, and I know of one instance  
5 where the anaesthetic staff of a hospital has not been  
6 able to persuade the hospital to provide the month of  
7 training in anaesthesia that the anaesthetic staff feel  
8 was desirable.

9 This, of course, is because the hospital  
10 then loses the service of the intern in other departments  
11 where the intern does relieve other staff so it is a  
12 little more expensive to have the intern on anaesthesia  
13 than on some other service because he needs to be so  
14 closely supervised.

15 DR. GILBERT: I would like to say empha-  
16 tically no, across the border the answer is no. At the  
17 time a recent graduate has just qualified he is not, he  
18 is legally qualified, he has to say he has given ten  
19 anaesthetics. That is why so much post-graduate work  
20 has to be done in anaesthesia.

21 Your question, I think, was: when a  
22 young doctor goes out to general practice is he quali-  
23 fied to give sometimes major anaesthetics and I think  
24 we all agree the answer to that is no.

25 DR. MORTON: I would agree with that.

26 COMMISSIONER BALTZAN: Could you  
27 possibly tell me what size of hospital, what size of  
28 community could support or is needed to encourage a  
29 full-time anaesthologist? I use the word anaesthetist  
30 and anaesthologist alternately and you will have to  
correct me on that.







1 THE CHAIRMAN: You wouldn't want them  
2 to take any significance in the word "engaged"?

3 COMMISSIONER BALTZAN: I didn't know  
4 what to substitute for employ.

5 THE CHAIRMAN: Require the service of.

6 COMMISSIONER BALTZAN: That is it.

7 DR. MORTON: We undertook a survey of  
8 our Society, Dr. Baltzan, and the number of anaesthetists  
9 who are working in towns of under 10,000 population is  
10 very small indeed. We have, in fact, 16 certificated  
11 anaesthetists who replied to our survey.

12 This doesn't mean all anaesthetists  
13 in Canada because all have not applied and do not 100%  
14 belong to the Society. Only 16 out of about 378 were  
15 actually working in communities of 10,000 population or  
16 less.

17 COMMISSIONER BALTZAN: 16 in 10,000 or  
18 less population. On page 2 you make reference to  
19 welcoming a lot, or a number of, foreign-trained  
20 specialists in your field, and conversely you have been  
21 doing a great deal of training of foreign students who  
22 come to our shores and this, I take it, is going to be  
23 a new and important role in Canadian medicine.

24 In relation to these people who come  
25 for the post-graduate work here, apart from the bits  
26 of service they render, is this an added cost to the  
27 hospital; medical school; the nation?

28 DR. MORTON: May I ask Dr. Gilbert to  
29 answer that question?

30 DR. GILBERT: I am sorry ---?





1 COMMISSIONER BALTZAN: I am taking  
2 cognizance of the fact you are providing a good deal of  
3 post-graduate training of foreign people; people from  
4 foreign countries coming here to acquire better training  
5 in your specialty.

6 Now, apart from the service that you  
7 get from them during the course of an anaesthetic, in  
8 actuality this is a cost to the hospital or to the  
9 medical college and to the nation?

10 DR. GILBERT: In our province it is a  
11 cost of the province.

12 COMMISSIONER BALTZAN: It is a cost?

13 DR. GILBERT: In our province. In the  
14 Province of Quebec the medical health scheme pays all  
15 interns and residents on a sliding scale.

16 COMMISSIONER BALTZAN: These people do  
17 not bring in, say, currency or enough to pay for this  
18 post-graduate training?

19 DR. GILBERT: Some of them, sir, get  
20 grants, but it is unusual. They get grants for research  
21 work but not for changing.

22 COMMISSIONER BALTZAN: No. 3, the question  
23 of subsidization of medical training following the  
24 patterns set by D.V.A. I am cognizant of paragraph 43,  
25 page 19. It is not yet clear to me - I think the time  
26 is too late unless you can direct me where that pattern  
27 is that I might look it up, or the members of the  
28 Commission. Would you supply it to us at another time?

29 THE CHAIRMAN: You are referring there  
30 to the way the servicemen were assisted to go to







1 university after the war?

2 DR. MORTON: Yes sir, that is correct.

3 COMMISSIONER BALTZAN: They were being  
4 paid while they were being trained, is that it?

5 DR. MORTON: They got an allowance in  
6 accordance with, I believe, the time that they had  
7 served, yes.

8 COMMISSIONER BALTZAN: Where would you  
9 want or expect this allowance to come from in civilian  
10 life?

11 THE CHAIRMAN: Come from the same place  
12 as it came from then: the Government.

13 DR. MORTON: If the people feel that  
14 this is a requirement, yes.

15 COMMISSIONER BALTZAN: Mr. Chairman, I  
16 think I am getting to the thing a little.

17 THE CHAIRMAN: I imagine well-organized  
18 programs as in any country after the war.

19 COMMISSIONER BALTZAN: You would like  
20 to see that applied?

21 DR. MORTON: We raise this for considera-  
22 tion, yes.

23 COMMISSIONER BALTZAN: Dr. Morton, No.  
24 3 on page 3, and I will only say this myself, the  
25 teaching departments of universities made specifically  
26 for this purpose, that we were talking about, in that  
27 you include also affiliated teaching hospitals or do  
28 you specifically say university departments?

29 Paragraph 3, last half; have you got it?

30 DR. MORTON: Yes sir.





1 COMMISSIONER BALTZAN: "Although our  
2 Society has a record of planning and  
3 achievement in this area of which we  
4 are proud, we would recommend considera-  
5 tion of grants to teaching departments  
6 of universities made specifically for  
7 this purpose."

8 Much of the training of your specialty  
9 is done also in teaching hospitals. Would it also  
10 apply to teaching hospitals or just university depart-  
11 ments? Would you extend it or are you just limiting it?

12 DR. MORTON: I think that we are limiting  
13 it to teaching departments of universities that are already  
14 set up because these departments are in some need.

15 The mechanisms by which these grants  
16 could be made are already reasonably well-established  
17 and you would have to, I believe, have much more elaborate  
18 mechanism for making these grants if you included more  
19 than the teaching department.

20 However, this might, at some time,  
21 become necessary.

22 COMMISSIONER BALTZAN: This would be  
23 sort of your first stage in that?

24 DR. MORTON: Yes.

25 COMMISSIONER BALTZAN: Thank you very  
26 much. I haven't got a page number but under "Best  
27 Possible Use of Existing Personnel", No. 5, top of the  
28 page:

29 "The provision of increased properly  
30 equipped out-patient facilities..."







1 You make certain recommendation for the provision of  
2 suitable out-patient facilities that may be necessary,  
3 and I suppose you also include extra personnel who have  
4 these added facilities.

5 We understand that there is now in the  
6 course some form of introduction of the existing Canadian  
7 Hospital Insurance Diagnostics Act which will extend  
8 services much more to the out-patient department.

9 You are in favour of extending the out-  
10 patient services department in hospitals?

11 DR. MORTON: Well, Dr. Baltzan, what  
12 we are talking about here are the actual physical facili-  
13 ties so that the anaesthetists' services that already  
14 exist in a hospital can be made the best possible use of.

15 COMMISSIONER BALTZAN: Thank you. That  
16 answers my question. Following upon that would you also  
17 be good enough to tell me, as you know the situation in  
18 Canada today, not limiting it to any particular area,  
19 if that portion of the Act were implemented, are the  
20 Canadian hospitals in a position to immediately go forth  
21 and render that out-patient service under this Act?

22 DR. MORTON: As far as anaesthetists  
23 giving anaesthetics I believe that the answer to this  
24 is no. They are not, not with adequate safety.

25 COMMISSIONER BALTZAN: I shall not ask  
26 you in connection with other services along that line.

27 One final question: you emphasize on  
28 page 19, 43, you would like to see some means for  
29 increasing interest and people entering into your  
30 specialty; that there is a great shortage. We have to







1 think, take things into perspective and I am sure that  
2 we all respect that, but also the claim is made,  
3 especially as I recall in connection with ophthalmolo-  
4 gists and otolaryngologists; they are in a worse position  
5 than you people are. You may or may not agree with  
6 that.

7 DR. MORTON: Well sir, in order to  
8 define what position you are in, you have to define  
9 what position you wish to fill.

10 COMMISSIONER BALTZAN: Relative state  
11 of each. Thank you very much.

12 COMMISSIONER STRACHAN: What is a  
13 closed anaesthetic department and how is it created?

14 DR. GORDON: A closed anaesthetic  
15 department, by the term "closed anaesthetic department"  
16 we mean a department in which certain individuals are  
17 appointed to the staff of a hospital. That is, they  
18 have privileges in the hospital. No practitioner who  
19 is not so appointed has the privilege of giving an  
20 anaesthetic in that hospital.

21 This is the situation which exists in  
22 other departments too and is regulated by hospital bylaws.

23 There are two purpose to be served by  
24 such a department. First is that this is a method by  
25 which the authorities responsible for the calibre of  
26 practice in a hospital regulate the qualification of  
27 the practice.

28 The second reason that any teaching  
29 hospitals associated with universities, the development  
30 of teaching is practical; only way the teaching staff





1 is defined in this way.

2 COMMISSIONER STRACHAN: Who makes the  
3 decision as to who will be included in that closed  
4 department or on whose advice?

5 DR. GORDON: I think it is usual  
6 that the decision, the recommendations are made, if  
7 we consider the ordinary hospital, on the advice of the  
8 Medical Advisory Board, the Medical Advisory Committee  
9 responsible ---

10 THE CHAIRMAN: Normal procedure. It is  
11 management.

12 DR. GORDON: It is management. In the  
13 university teaching hospitals the appointments are made  
14 on the advice of hospital authorities and the universities.

15 COMMISSIONER STRACHAN: If a fully-  
16 qualified anaesthetist came along would he have any  
17 trouble getting into that closed department?

18 DR. GORDON: It depends; first let me  
19 say it would depend on the hospital and on the hospital  
20 bylaws. There are some hospitals to whom the qualifica-  
21 tion of the individual is not a consideration provided  
22 he works in that community.

23 In teaching institutions it is likely  
24 to depend on the need for additional personnel to deal  
25 with the teaching load.

26 THE CHAIRMAN: Is there any special  
27 procedure applicable to anaesthetists that are not  
28 applicable to all the rest of the staff?

29 DR. GORDON: No, none whatever.

30 THE CHAIRMAN: Same procedure?







1 DR. GORDON: Same procedure.

2 COMMISSIONER STRACHAN: Is membership  
3 in your organization compulsory?

4 DR. GORDON: No, it's a voluntary  
5 organization. An individual may belong to this organiza-  
6 tion or he may choose to remain outside.

7 COMMISSIONER VAN WART: Just one  
8 question. On page 19, the sentence occurs three or  
9 four times in your brief:

10 "A period of directed service upon  
11 graduation would seem to us a reasonable  
12 requirement."

13 Now, the word "directed" has always  
14 been put in quotation marks. Will you explain what you  
15 mean by directed?

16 DR. MORTON: Yes, Dr. Van Wart.ordi-  
17 narily when a young man completes what he regards as  
18 sufficient training, what he chooses to do for himself,  
19 he makes his own personal arrangements. We have discussed  
20 in the brief the various mechanisms that operate for  
21 the distribution of an anaesthetist across the country.

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1 We were simply saying here that it did not seem  
2 unreasonable to us for the Canadian nation to expect  
3 if they had assisted a man who acquired this  
4 additional competency that they could possibly expect in  
5 exchange by giving some service.

6 THE CHAIRMAN: Stay in Canada for a certain  
7 period.

8 DR. MORTON: That is correct. Of course, it  
9 is open to a very wide choice. The D.V.A., of  
10 course, had done a very great service to their  
11 country.

12 COMMISSIONER VAN WART: When you say he  
13 shall have free choice of location, you are suggesting  
14 that he stay in Canada?

15 DR. MORTON: We stated here a period of  
16 directed service, by which we meant the amount which  
17 might have any relationship to the amount of  
18 assistance he had received. I would think it would  
19 be a reasonable hope, in facing the problems of this  
20 nation, that a certain number of men, supposing you  
21 sent them into areas, offered them a list of areas  
22 where help was needed and he chose to work in that  
23 area, I think we could expect a certain percentage of  
24 them to stay there. Very often people after being  
25 there wish to stay there. I don't believe any sort  
26 of compulsion should be used here. It might be  
27 worthy of consideration that distribution of service  
28 could be improved slightly in this way.

29 COMMISSIONER VAN WART: Who would do the  
30 direction? The person who advanced the subsidy?





1 THE CHAIRMAN: Well, we have the plan; it  
2 is fairly well accepted. You have it in dentistry  
3 where they are subsidized by the province of Newfoundland,  
4 and there is an undertaking in advance, if you accept  
5 the help you go back and do some work. That is the  
6 way the direction comes about, it is not done afterwards,  
7 but it is a condition of accepting the grant. Is  
8 that what you mean?

9 DR. MORTON: Yes.

10 DR. GORDON: The same thing in the armed  
11 services.

12 COMMISSIONER VAN WART: We had the two  
13 statements which were in conflict with each other, the  
14 man should have the choice where he should go and then  
15 you have this directive.

16 DR. GORDON: Perhaps it is the final choice,  
17 which suggests to me he doesn't have to stay where he  
18 is sent.

19 THE CHAIRMAN: Thank you very much, Dr.  
20 Morton and all your associates. It has been a very  
21 profitable morning; you may think it has been a  
22 very provocative one. We find we can perhaps do  
23 better if we get people to get their dander up, and  
24 it is always a mistake to accept the suggestion that  
25 because questions are along certain lines they  
26 suggest any preconceived notions. But we are anxious  
27 to find out what the people appearing before us do  
28 think and that they can give us enlightenment in the  
29 area where we need help. Thank you very much.  
30







1 MR. HALL: Mr. Chairman, the next submission  
2 is by the Federated Women's Institutes of Canada.  
3 Their brief will be filed as Exhibit No. 204.  
4 Representing the Federated Women's Institutes of  
5 Canada are Mrs. James Haggerty and Mrs. Ethel White,  
6 who will be presenting the brief.

7 ---EXHIBIT NO. 204: Submission of Federated Women's  
8 Institutes of Canada.

9 SUBMISSION OF FEDERATED WOMEN'S INSTITUTES OF  
10 CANADA

---

11 APPEARANCES: Mrs. James Haggerty

12 Mrs. Clyde B. White.

13 MRS. WHITE:

14 The Federated Women's Institutes of Canada  
15 desire to thank the Royal Commission on Health Services  
16 for this opportunity to express their views on these  
17 most important subjects.

18 FORWARD

19 The Federated Women's Institutes of Canada  
20 are National in character, comprising a membership of  
21 75,000 women. It coordinates the various provincial  
22 units and initiates nation wide projects. It is an  
23 organization of rural women whose aims and objects  
24 are to promote the welfare of the Canadian home and  
25 serve the community life of Canada through a program  
26 of adult education, to initiate nation-wide campaigns  
27 in accordance with the Federation, and to speak for  
28 the organization on a national level. To promote and  
29 extend their work, standing committees are set up, among  
30 these is Home Economics and Health.

The Federated Women's Institutes of Canada  
have carried out studies and surveys and have encouraged





1 the practical application of improved health measures.  
2 A continuing active participation is recorded of the  
3 membership's activities in studies and surveys of pre-  
4 natal, maternity and child health; in cancer and  
5 "Well Women's Clinics"; Mental Health; First Aid and  
6 Home Nursing; in Farm, Home and Highway Safety;  
7 Swimming and Water safety; Studies of Nutrition,  
8 Catering and Diets; and of National Health Insurance  
9 Plans.

10 During the immediate past Biennial, a survey  
11 of Canada's eating habits was made in eight of the  
12 ten provinces, with the direction of the National  
13 Convener of Home Economics and Health, under the caption  
14 "Eat to Live", and a comprehensive report of this  
15 survey was presented to the National Convention of the  
16 Federated Women's Institutes of Canada in June 1961.  
17 The membership raise money for local needs for  
18 hospitals and sanitarium, senior citizens' homes,  
19 mentally handicapped schools and facilities, and for  
20 health projects and needs according to the local  
21 requirements. Therefore, the Federated Women's  
22 Institutes of Canada are continually interested in  
23 health care.

24 PURPOSE

25 The purpose of this brief is to show an  
26 interest in some problems of health care and to offer  
27 our services in rural areas and small communities  
28 in introducing and sponsoring educational programs  
29 and projects and to support other organizations,  
30 departments, and agencies who participate in any plan







1 plan to raise the standard of health among our  
2 Canadian people. It has been said, "Health is a state  
3 of complete physical, mental and social well-being  
4 and not merely the absence of disease or infirmity.  
5 The health of our nation of tomorrow depends on the  
6 health of our children (people) today"; was aptly  
7 stated by the Hon. Emmett M. Hall of the Royal  
8 Commission on Health Services. Inadequate health  
9 means a lower standard of living, and like unemployment  
10 is the largest economic waste a nation can have.

11 CONTENTS OF BRIEF

- 12 1. Chronic Patients Rehabilitation Program.
- 13 2. Outpatient Clinics.
- 14 3. Homemaker Services.
- 15 4. Extension of Nursing Service under Public  
16 Health.
- 17 5. Physicians and Surgeons Insurance.

18 1. CHRONIC PATIENTS REHABILITATION PROGRAM

19 In most provinces when a patient is termed  
20 "chronic" they are transferred to a nursing infirmary or  
21 boarding home, in order to free hospital beds for  
22 critically ill and surgical cases.

23 There is a need for more chronic hospitals  
24 and homes-- some patients might live at home with their  
25 families if there was sufficient supervision and some  
26 help with nursing care. Outpatient clinics could be  
27 of service here as the treatment could be carried out  
28 here, any drastic changes in condition or surgery would  
29 necessitate admittance to hospital.

30 There is a need for chronic patients





1 rehabilitation centres; here counselling service is  
2 needed. This is now done in a limited way of public  
3 health services in some areas, but much more should  
4 be done along these lines.

5       There is a need for more homes for the aged,  
6 many of whom are pensioners and those from small  
7 income groups. None in lower income brackets can  
8 afford private boarding homes and hospitals. Many  
9 communities are realizing the need as shown by their  
10 low income housing projects, but the demand exceeds the  
11 supply.

## 12 2. OUT-PATIENT CLINICS

13       There is a need for more out-patient clinics  
14 all across the nation. These could well be in connection  
15 with hospital services. Many tests and simple  
16 treatments could be taken care of here; counselling and  
17 guidance could be given under a trained staff, thus  
18 lessening the demand for doctors' services and telephone  
19 calls to doctors' offices. Any change in condition  
20 would be referable to patient's doctor.

21       Ill health that plagues families creates  
22 problems for them and their difficulties increase if  
23 they are unemployed. Here counselling services would  
24 be of help.

## 25 3. HOMEMAKER SERVICES

26       Some provinces have this under service clubs,  
27 and some have instituted pilot schemes. There is a  
28 desperate need for a subsidized plan; in all cases  
29 everywhere, the demand exceeds the supply.

30       Homemaker services can be used in prevention







1 on occasion of physical and family breakdown. The  
2 primary function is to furnish home help to families  
3 with children, acutely ill, convalescent, disabled  
4 or chronic cases, and to maintain the routine of the  
5 home in time of stress, especially if it is the  
6 mother who is to be hospitalized. By use of a  
7 homemaker she would be free to go and have the needed  
8 operation or treatment when it was needed most. If  
9 there was some competent person in the home to take  
10 charge, a patient could often be discharged from  
11 hospital to convalesce at home, thus freeing beds  
12 in hospitals for critically ill.

13 Homemakers would need to be carefully  
14 screened, preferably mature women who have already  
15 been successful homemakers in their own right. Good  
16 health and stable character, personality and  
17 flexibility should be necessary to enable her to cope  
18 with a variety of home situations, especially in homes  
19 of mentally retarded or confused persons. Here use  
20 might be made of retired nurses on a voluntary basis to  
21 interview and train these women and perhaps staff an  
22 agency. In many cases a homemaker might not need much  
23 training, but a brief period of such indoctrination  
24 would give her confidence. This might be partially  
25 financed, as the extended public health nursing is now  
26 in some provinces, by a small per capita tax. In  
27 some provinces homemakers are supplied to certain cancer  
28 patients by a Division of the Cancer Society.

29 In Australia, in a questionnaire, findings  
30 showed "Home Help" as urgent as housing and rated top







1 priority.

2           There would be a need to differentiate  
3 between "Homemaker" and "Housekeeper". A Homemaker  
4 would take the place of the absent mother and perhaps  
5 needs a variety of skills -- whereas a housekeeper  
6 might be used to do housework under guidance of someone  
7 in authority in the family and thus have little  
8 responsibility.

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4. EXTENSION OF NURSING SERVICE UNDER PUBLIC HEALTH

In some Provinces a nursing service, similar to Victorian Order of Nurses, is in use. This is financed by a small per capita tax. The nursing service is available to all who ask for it, under a doctor's supervision - up to an hour and half of nursing care per diem, exclusive of meals and housework. This enables many convalescent and chronic patients to go home to their families who with this service available are able to care for those who might otherwise have to be hospitalized, thus freeing hospital beds for patients who need more care.

Cancer patients could have dressings changed or other treatments given in the home by this service.

A crippled man who has been unable to have a tub bath for years, except in hospital, now enjoys a weekly "tub" by use of this nursing service. Many more cases could be cited where this service could bring comfort to a patient and free his or her family from unnecessary worry and strain. Many people need merely reassurance and help while struggling with diets and treatments; this would thus free doctors and staff from unnecessary phone calls, and visits to offices and clinics.

5. COMPREHENSIVE MEDICAL AND SURGICAL INSURANCE

A comprehensive medical and surgical insurance is needed for groups not now covered, at a price they can afford. To date the only insurance available to individual families and those not covered







1 by group plans, is the high cost private policies beyond  
2 the means of those of low income.

3 Retired people, individuals not covered  
4 by group insurances, are unable to get a comprehensive  
5 medical and surgical insurance plan except through  
6 private agencies at prices prohibitive to their means.  
7 Farmers and small business men could be ruined finan-  
8 cially by an extended illness. To date most private  
9 plans are inadequate and expensive. These are major  
10 threats to economic security: death, old age, unemploy-  
11 ment and illness.

12 We would recommend a blanket service  
13 that would include preventative treatment and rehabilita-  
14 tion which would embrace all branches of medical service,  
15 including drugs and medicine and ambulance service. At  
16 present, with private insurance, a subscriber who makes  
17 no claims, gets no benefits. A subscriber who pays these  
18 premiums should be able to build up a reserve or backlog  
19 for care when they are no longer able to pay, instead of  
20 being classed as indigents.

21 In the past many people have indicated  
22 that they would like to have benefits similar to group  
23 plans at low cost, previously available only to groups  
24 of employees or organizations where such plans are in  
25 effect. This might call for an overall national plan,  
26 but it should ensure that every resident of Canada has  
27 access to the care he needs regardless of age, physical  
28 condition or occupation, and should ensure sufficient  
29 coverage so as not to deter a patient from seeking the  
30 health care he needs.





1 The Federated Women's Institutes of  
2 Canada recommend a program of recruitment, training and  
3 remuneration sufficient to ensure a continuing supply of  
4 technical personnel. A national plan to provide a  
5 reasonable and equal distribution of services and facili-  
6 ties across Canada is also recommended.

7 The Federated Women's Institutes of  
8 Canada would continue to stimulate public interest, to  
9 support particular health needs, and to spread awareness  
10 of new health care and techniques, to ensure that every  
11 resident of Canada has access to the health care he needs  
12 at a time when he needs it, regardless of his ability to  
13 pay at the time of service.

14 Although a Federal Health Plan would  
15 seem to have advantages, Provincial attitudes must be  
16 considered, but Federal grants, administered by Provinces,  
17 seem to be most favoured for a nation-wide health plan.  
18 Ill health should have more recognition than is now  
19 given to it; it is a grave threat to inadequate incomes.  
20 Protection against this and the cost of medical expenses  
21 should be considered in an overall Social Security Plan.

22 "Health is a state of complete Physical,  
23 Mental and Social Well-being and not merely an absence  
24 of disease or infirmity." (From Constitution, World Health  
25 Organization).

26 CONCLUSION

27 If we are all to enjoy the highest  
28 levels of health everyone must work to this end and  
29 support projects and educational programmes that emphasize  
30 the health and safety of the individual. This is the







1 responsibility of us all. The Federated Women's  
2 Institutes of Canada would co-operate with other organiza-  
3 tions in any Health Care objectives that will encourage  
4 and provide all individuals and families to keep to a  
5 minimum the incidence of illness and the need for health  
6 care services.

7 The Federated Women's Institutes of  
8 Canada will work to secure a balanced health care program  
9 facilities and services of the highest standard, readily  
10 available and adequate to meet the needs of all Canadians  
11 and to ensure that every resident has the needed care  
12 when he needs it without consideration of his ability to  
13 pay the cost at the time of service.

14 THE CHAIRMAN: Thank you very much,  
15 Mrs. White. Do you wish to add anything, Mrs. Haggerty?

16 MRS. HAGGERTY: No, I would like to  
17 say that we do thank you for the privilege of submitting  
18 this brief, and Mrs. White is the Chairman of our  
19 Committee on Health and Home Economics, and I feel that  
20 we have been interested, for 65 years now, in the health  
21 of our country, and we feel we have expressed in this  
22 brief some of our recommendations, and some of the  
23 things that we have been doing for a number of years.

24 THE CHAIRMAN: Thank you, Mrs. Haggerty.  
25 I think there may be some questions, some explanations,  
26 that some of the members may wish, but for a moment I  
27 would like to say that we are grateful to you for having  
28 prepared the brief, and for being here to represent the  
29 consumer element in this debate, and at the family  
30 or grass roots level, and therefore your views are







1 extremely important, and it is desirable that we do  
2 hear from organizations such as yours.

3 Now, I don't want to attempt to para-  
4 phrase your brief too narrowly. As I understand it,  
5 it is this, that you are very interested in some form  
6 of program that will give comprehensive medical and  
7 surgical coverage at a price that those who need that  
8 service can pay, and that you are not necessarily  
9 wedded to any particular plan, but any plan that will  
10 accomplish the thing you have in mind would suit you?

11 MRS. HAGGERTY: That is fine.

12 COMMISSIONER BALTZAN: Ladies, I  
13 compliment you and your Institute for the clarity of  
14 your submission. For the reason of your clarity I  
15 have no specific questions. Thank you.

16 COMMISSIONER GIRARD: Mr. Chairman,  
17 Mrs. Haggerty or Mrs. White, it does not matter which  
18 one chooses to answer the question.

19 On page 4, paragraph 4, pertaining to  
20 the extension of nursing service under Public Health,  
21 the paragraph reads:

22 "In some provinces a nursing service,  
23 similar to Victorian Order of Nurses,  
24 is in use. This is financed by a  
25 small per capita tax. The nursing  
26 service is available to all who ask  
27 for it, under a doctor's supervision..."

28 And you go on to say that you would  
29 like such service to be more widespread. Would you  
30 please tell us why you would advocate this service,





1 which is similar to V.O.N., but is tax-supported,  
2 instead of asking V.O.N. to open more branches wherever  
3 they are needed. Is there a special reason?

4 MRS. WHITE: I was instrumental in  
5 getting this started in the vicinity of British Columbia,  
6 from which I come, and it has worked very well in connec-  
7 tion with Public Health. Our Public Health Department  
8 started a pilot scheme in the Okanagan Valley back quite  
9 a while. It seemed to work, and doctors have started  
10 this under the Department of Public Health in the  
11 interior of British Columbia this past year.

12 The Victorian Order of Nurses, we don't  
13 have it in all our areas, and they do make a charge for  
14 the service. You can pay or not as you like. If you  
15 can pay you are expected to pay, but if not they still  
16 give the service.

17 Under this Public Health nursing service,  
18 this does not seem to conflict with the Victorian Order,  
19 and I have had the personal experience of people who  
20 are discharged from hospital to live with their families.

21 For example, a cancer patient who has  
22 to have a dressing changed. A Public Health Nurse goes  
23 out to change the dressings. You have liver shots or  
24 hypodermics, or any other medical care to be given.

25 That is given under this nursing service.  
26 The family can take care of them except for these speci-  
27 fic treatments. It does free hospital beds for critically  
28 ill patients. Otherwise these patients might have to go  
29 into a nursing home, or pay other high cost services to  
30 take care of this work, and we do find that it is working







1 very well in our rural areas.

2 They have had to add to their staff a  
3 little bit, but that is where the graduate nurses, the  
4 volunteer nurses, come in. They can recruit these  
5 nurses in the communities when needed, and it is all  
6 done under the supervision of the doctor.

7 COMMISSIONER GIRARD: The point of my  
8 question was, do you advocate this because, is one  
9 reason that V.O.N.'s don't go too deeply into the  
10 rural areas, because it is difficult sometimes to  
11 establish a branch there, or the other point that you  
12 said, the V.O.N. charge according to what you can pay  
13 or do you seem to imply that the other one is free,  
14 because it is not. It is tax-supported.

15 MRS. WHITE: No, I didn't mean that.  
16 There seems to be a place for both, and there does seem  
17 to be a need for this kind of service.

18 COMMISSIONER GIRARD: I think there is  
19 a need, and I just wanted to get the idea.

20 MRS. WHITE: I didn't mean to say that  
21 the V.O.N., on account of the charge, because it is a  
22 very small charge.

23 COMMISSIONER GIRARD: It is a voluntary  
24 agency, and the other is tax-supported.

25 MRS. WHITE: That is right.

26 COMMISSIONER GIRARD: On the same page  
27 you talk about Homemaker Services. We have heard a  
28 great deal about Homemaker Services in previous briefs,  
29 and we feel that they are very essential. You quoted  
30 Australia as saying they are as highly needed as housing,





1 and we believe they are. You say:

2 "This might be partially financed,  
3 as the extended public health nursing  
4 is now in some provinces, by a small  
5 per capita tax."

6 Would you see Homemaker Services as  
7 individual services, or as an extension of certain health  
8 agencies, visiting nursing services, or others?

9 MRS. WHITE: I think I would say that  
10 they were an extension of certain agencies, for instance,  
11 possibly under Public Health.

12 COMMISSIONER GIRARD: Some family agen-  
13 cies have homemakers in their agencies?

14 MRS. WHITE: Yes.

15 COMMISSIONER GIRARD: There is one  
16 V.O.N. branch that has also Homemaker Services in their  
17 agency for the people that V.O.N. serves?

18 MRS. WHITE: Yes. They could be under  
19 any other volunteer agency that happened to be interested  
20 in that sort of thing.

21 COMMISSIONER GIRARD: Do you visualize  
22 this Homemaker Service as an independent service, or  
23 with another agency, within some other agency?

24 MRS. WHITE: Yes, but they would have  
25 to be supervised.

26 COMMISSIONER GIRARD: Do you think it  
27 is easier for them to be supervised in an agency, a  
28 family welfare agency?

29 MRS. WHITE: No, not necessarily. If  
30 there was a group that were responsible enough to take





1 over and to staff the agency.

2 COMMISSIONER GIRARD: If it is an inde-  
3 pendent agency, could any other of the community health  
4 agencies call on this Homemaker Service agency?

5 MRS. WHITE: Yes.

6 COMMISSIONER GIRARD: You would see it  
7 then as a centralized service?

8 MRS. WHITE: Yes, centralized.

9 COMMISSIONER GIRARD: Which could  
10 serve any other health agency in the community, but  
11 tax-supported?

12 MRS. WHITE: Yes.

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1 COMMISSIONER GIRARD: Would there be any  
2 charge in your mind made to the family for this  
3 service if they can pay?

4 MRS. WHITE: Of course, we are just a lay  
5 organization and the financing of these things we  
6 do not have too many opinions on. I think what  
7 has entered our minds with this homemaker service  
8 was something similar to what the welfare does in  
9 some provinces now, they do provide housekeeping  
10 services.

11 COMMISSIONER GIRARD: They would be entirely  
12 tax supported and the families that are receiving the  
13 services of these homemakers would not have anything  
14 to pay towards their salary?

15 MRS. WHITE: That is right. This would need  
16 to be subsidized by someone, either tax supported or  
17 some volunteer agency.

18 COMMISSIONER GIRARD: Or fall under the  
19 community itself?

20 MRS. WHITE: Yes.

21 COMMISSIONER GIRARD: You can see them in  
22 different patterns?

23 MRS. WHITE: I can see them in different  
24 patterns.

25 COMMISSIONER GIRARD: You also state on  
26 the first page that your organization, the Federated  
27 Womens' Institutes of Canada have carried out surveys  
28 on different things, child health, cancer, well  
29 women's clinics, have you made available to the  
30 Commission some of the reports of these surveys or





1 could you make these available to us?

2 MRS. HAGGERTY: They could be made available.  
3 We did not do this but they can be made available.

4 COMMISSIONER GIRARD: As a rule we are  
5 interested in any report that has been done in the  
6 health field and we would be grateful to you if you  
7 would forward to the Secretary any of the reports of  
8 studies or surveys that you have done in these areas.

9 MRS. HAGGERTY: We will be very happy to do  
10 that.

11 COMMISSIONER STRACHAN: May I say I personally,  
12 and I trust the Commission, would like to have a copy  
13 of the report "Eat to Live".

14 MRS. HAGGERTY: That will be available.

15 COMMISSIONER GIRARD: Thank you very much.

16 COMMISSIONER FIRESTONE: Can we turn to page  
17 6 in your first paragraph and you say:

18 "...every resident of Canada  
19 has access to the health care he  
20 needs at a time when he needs it,  
21 regardless of his ability to pay  
22 at the time of service."

23 I take it that is one of your recommendations?

24 MRS. WHITE: Yes.

25 COMMISSIONER FIRESTONE: Then, in the next  
26 paragraph you say, and I quote:

27 "Although a federal health  
28 plan would seem to have advantages,  
29 provincial attitudes must be  
30 considered, but federal grants,







1 administered by the provinces,  
2 seem to be most favoured for a  
3 nation-wide health plan."

4 Are you recommending that the federal  
5 government give grants to the provinces and the  
6 provinces administer a national or provincial health  
7 care plan in that province?

8 MRS. WHITE: That is right.

9 COMMISSIONER FIRESTONE: Then you realize that  
10 if we have such a state supported national plan in  
11 existence in Canada some of the money may come from  
12 payments of premiums, some may come from taxes. Now,  
13 if some of the money comes from taxes it may mean higher  
14 taxes; would your group, and you represent 75,000  
15 women in this Federated Womens' Institutes of Canada,  
16 support such higher taxes to pay part or whatever  
17 part of health costs are required to be paid out of  
18 taxes?

19 MRS. HAGGERTY: I think they would if the  
20 health services were better.

21 COMMISSIONER FIRESTONE: Thank you. One  
22 last question; would you include dental care service  
23 in such a comprehensive health care plan?

24 MRS. HAGGERTY: I would think so because  
25 that is very essential.

26 COMMISSIONER FIRESTONE: Thank you very much.

27 COMMISSIONER VAN WART: I understand your  
28 organization is more of a rural organization?

29 MRS. HAGGERTY: Primarily.

30 COMMISSIONER VAN WART: Have you many groups





1 in your rural organization insured under any of the  
2 plans for health care?

3 MRS. HAGGERTY: We did have quite a number  
4 of years ago under the Blue Cross but that has been  
5 done away with of late years because we found that  
6 our women were insured with their families, under  
7 various group plans and cooperative plans.

8 COMMISSIONER VAN WART: Do you encourage at  
9 all rural groups taking out insurance for health  
10 plans?

11 MRS. HAGGERTY: Oh yes, we do encourage it.

12 COMMISSIONER VAN WART: And at the present are  
13 there many now or have they as groups not been insured?

14 MRS. HAGGERTY: Do you mean are many of  
15 our women insured?

16 COMMISSIONER VAN WART: Women in your  
17 organization?

18 MRS. HAGGERTY: Yes, there are. I could not  
19 tell you the percentage but it would be quite a large  
20 percentage.

21 COMMISSIONER VAN WART: And are they finding  
22 it satisfactory?

23 MRS. HAGGERTY: As far as insurance goes,  
24 yes.

25 COMMISSIONER VAN WART: Thank you.

26 COMMISSIONER STRACHAN: I have no questions,  
27 Mr. Chairman.

28 THE CHAIRMAN: Thank you very much, Mrs.  
29 Haggerty and Mrs. White, we are grateful to you  
30 and we appreciate your courtesy in waiting this





1 morning.

2 MRS. HAGGERTY: Thank you.

3 THE CHAIRMAN: We will now rise and reconvene  
4 at 10:00 o'clock Monday morning.

5 ---Adjournment.

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# ROYAL COMMISSION ON HEALTH SERVICES

## HEARINGS

HELD AT

OTTAWA

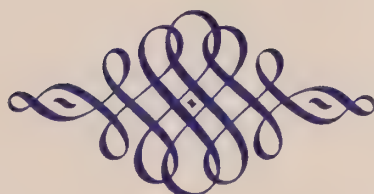
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1  
2 ROYAL COMMISSION ON HEALTH SERVICES

3  
4 Proceedings of the hearing  
5 held in Ottawa, Ontario on the  
6 26th day of March, 1962.

7 COMMISSION MEMBERS:

8 Chief Justice EMMETT M. HALL -- Chairman

9 Miss ALICE GIRARD, R.N.

10 Dr. C.L. STRACHAN

11 Dr. ARTHUR F. VAN WART

12 Mr. M. WALLACE McCUTCHEON, Q.C.

13 Prof. O.J. FIRESTONE

14 Dr. DAVID M. BALTZAN

15  
16 COMMISSION COUNSEL:

17 Mr. R.N. HALL, Q.C.

18 COMMISSION SECRETARY:

19 Mr. N. Lafrance  
20  
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The Ottawa General Hospital 7699

St. Louis Marie de Montfort Hospital 7730

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Ottawa, Ontario,  
Monday, 26th  
March, 1962.

---On resuming at 10:00 a.m.

MR. HALL: Mr. Chairman, the next submission is that of the Canadian Nurses' Association. The brief filed by the Association will be Exhibit No. 205.

---EXHIBIT NO. 205: Submission by the Canadian Nurses' Association.

SUBMISSION BY THE CANADIAN NURSES' ASSOCIATION

APPEARANCES:

Miss Helen Carpenter

Miss E.A. Electa MacLennan

Reverend Sister Madeleine De Jesus

Miss M. Pearl Stiver

Miss Lillian Campion

Mr. Gordon F. Henderson, Counsel.

MR. HALL: Mr. Gordon F. Henderson, the Association counsel will introduce the members of the delegation.

MR. HENDERSON: Mr. Chairman and ladies and gentlemen of the Commission. It is my privilege to introduce to you the delegation before you. The Canadian Nurses' Association was first formed in 1908. It was incorporated by Act of Parliament of Canada in 1947 and has had a distinguished history.

Appearing on behalf of this Association and presenting the brief will be Miss Helen Carpenter, the President of the Association. Miss Carpenter is Assistant Professor School of Nursing at the University





1 of Toronto and Miss Carpenter, as I say, will present  
2 the brief to the Commission.

3 With Miss Carpenter will be Miss E.A. Electa  
4 MacLennan, First Vice President of the Canadian  
5 Nurses' Association who is Director of Nursing,  
6 Dalhousie University at Halifax. Perhaps Miss  
7 Carpenter will stand so she will be identified to the  
8 Board. And, Miss MacLennan, the First Vice President  
9 of the Association.

10 A member of the delegation Reverend Sister  
11 Madeleine De Jesus, Chairman of the Committee on  
12 Legislation and By-laws and Professor of Nursing  
13 Education, the University of Ottawa School of Nursing  
14 in Ottawa.

15 The Commission may be interested to know that  
16 Reverend Sister Madeleine De Jesus also appeared at  
17 the time the Association presented its brief to the  
18 Haggerty Commission in the years 1942 and 1943.

19 As a member of this delegation Miss M.  
20 Pearl Stiver, Executive Director Canadian Nurses'  
21 Association in Ottawa.

22 Another member of this delegation, Miss  
23 Lillian Campion, Consultant in Nursing Service,  
24 Canadian Nurses' Association, Ottawa and it is my  
25 happy privilege, Mr. Chairman, Miss Girard and  
26 gentlemen, to ask Miss Carpenter to present the brief  
27 on behalf of the Association.

28 MISS CARPENTER: Mr. Chairman and Members  
29 of the Royal Commission on Health Services, it is  
30 my privilege to present the submission of the Canadian







1 Nurses' Association to this Royal Commission.

2 Summary Statement

3 The Canadian Nurses' Association with a  
4 membership of 63,822 is a federation of the ten  
5 provincial registered nurses' associations. It was  
6 formed in 1908 as an affiliation of existing nursing  
7 organizations in Canada and was incorporated in 1947.  
8 The Association's original purpose was to provide a  
9 link with the International Council of Nurses, an  
10 organization with which Canadian nurses have been  
11 associated since 1899.

12 Through the evolution of time and experience,  
13 the primary function of the Canadian Nurses'  
14 Association has come to be a fostering of high standards  
15 of nursing practice in Canada to the end that the  
16 highest possible level of health may be achieved by the  
17 people. The promotion of maximum health is the basis  
18 of the profession's concept of nursing care.

19 Membership in the Canadian Nurses' Association  
20 is obtained through membership in one of the provincial  
21 nurses' associations, each of which is authorized by  
22 provincial legislation to grant registration.

23 A registered nurse is represented in local  
24 and provincial matters by her provincial association;  
25 in national and international affairs by the Canadian  
26 Nurses' Association.

27 The headquarters of the Canadian Nurses'  
28 Association is at 74 Stanley Avenue, Ottawa 2, Canada.

29 The information contained in this brief is  
30 presented to assist the members of this Commission in





1 their studies of Canada's health services.

2 SUMMARY AND RECOMMENDATIONS

3 It is the concern of the Canadian Nurses'  
4 Association that the best possible nursing care --  
5 to promote, maintain or restore health -- be available  
6 at all times to all people in Canada. The overall  
7 organization of health services and their financing  
8 are subjects for government legislation and the  
9 Canadian Nurses' Association does not propose to make  
10 recommendations on these subjects. At the same  
11 time, the nursing profession has a responsibility to  
12 define its position and function within society, to  
13 evaluate its work and the educational standards of  
14 its members, and to adjust both its work and  
15 educational program to meet changing needs.

16 There are several groups of personnel giving  
17 nursing care. The Canadian Nurses' Association  
18 represents only one of these, the registered nurse, i.e.,  
19 graduate either of a three year hospital school program  
20 or a four or five year university school program, and  
21 of two experimental programs (Metropolitan  
22 Demonstration School of Nursing and Nightingale School  
23 of Nursing, Toronto).

24 Canada is favourably situated in relation to  
25 the number of nurses to the total population of the  
26 country. There is, at present, approximately one  
27 registered graduate nurse in Canada for every 260  
28 people. While this ratio is favourable in  
29 comparison with that existing in most countries, Canada  
30 does suffer from a seeming shortage of nurses.

Science and technology are advancing rapidly







1 in the entire field of health. The standards of  
2 nursing care available now and available in the future  
3 will depend on the ability of the profession to produce  
4 members trained and capable of adjusting to and  
5 advancing with the developments in science and  
6 technology.

7 The opportunity available in industry of  
8 enabling an individual to be more effective or to  
9 produce more work through mechanization and automation  
10 is not generally available to the nursing profession.

11 Because of the nature of the service a nurse  
12 performs, the time needed to provide nursing care is not  
13 reduced by technological progress. In addition, the  
14 general trend toward shorter working hours experienced  
15 in most of business and industry in Canada must  
16 necessarily affect the working hours of the nurse. As  
17 the services to be performed, as far as one can  
18 anticipate, will not diminish, the only way of ensuring  
19 that there will be sufficient nurses to provide this  
20 care will be by increasing the number of nurses in  
21 relation to the total population.

22 It is the opinion of the Association that the  
23 quality of nursing service depends on five factors:

- 24 i. The personal attributes of the nurse;
- 25 ii. The education of the nurse;
- 26 iii. The proficiency of the nurse;
- 27 iv. The conditions under which the nurse renders  
28 service.
- 29 v. The quantity of nursing service available.
- 30 The proficiency and personal attributes of the





1 nurse will depend in large measure on the general and  
2 professional education she has received. In this  
3 connection we believe it is pertinent to mention that  
4 during 1929-1931, Dr. G.M. Weir, of the University of  
5 British Columbia, on behalf of the Canadian Medical  
6 and Canadian Nurses' Association, conducted a survey  
7 of conditions in the hospital schools of nursing and  
8 of the working conditions of nurses. His report,  
9 published in 1932, pointed to many areas where  
10 substantial improvements would lead to improved nursing  
11 care.

12 Thirty years later, it is clear that some of  
13 the problems exposed by Dr. Weir have still to be  
14 settled, notably:

15 The question of how nursing  
16 education should be organized and  
17 financed;  
18 the lack of standardization among  
19 nursing education programs; and  
20 The paucity of nursing service in  
21 rural areas.





1 We believe it is also pertinent to  
2 record that in 1960, at a cost of \$65,000, The Canadian  
3 Nurses' Association completed a Pilot Project for the  
4 Evaluation of Schools of Nursing in Canada. The purpose  
5 of this examination of schools of nursing in Canada was  
6 to determine their readiness for a program of national  
7 voluntary accreditation. Twenty-five hospital schools  
8 were surveyed, representing a reasonably reliable cross-  
9 section of hospital schools throughout Canada. The survey  
10 indicated that, of the schools surveyed, only 16% met the  
11 standards desired by the profession; 84% failed to meet  
12 these standards and at that time would not have qualified  
13 for accreditation had such a program existed. It is  
14 significant also that many of the weaknesses pointed out  
15 by Dr. Wier in his report were found to be still in  
16 existence.

17 As a result of the Pilot Project, the  
18 following recommendations were made in 1960 and were  
19 accepted by the members of the Canadian Nurses' Association:

- 20 1. That a re-examination and study of  
21 the whole field of nursing education be  
22 undertaken;
- 23 2. That a school improvement program  
24 be initiated to assist schools in  
25 upgrading their educational programs;
- 26 3. That a program be established for  
27 evaluating the quality of nursing service  
28 in the areas where students in schools  
29 of nursing receive their clinical  
30 experience;







1 4. That a program of accreditation  
2 for schools of nursing be developed  
3 by the Canadian Nurses' Association.

4 Work is now in progress on the first three recommendations.

5 It is the opinion of the Canadian Nurses'  
6 Association that the preparation of a nurse is essentially  
7 an educational experience and an educational process. As  
8 such, the standard of training and education would be  
9 improved by placing the responsibility for this educa-  
10 tional process under educational authorities. Such a  
11 step should not deprive the nursing student of clinical  
12 experience in the hospital and other health agencies.  
13 Rather, it is a recognition of the fact that the educa-  
14 tional process of the student should not be secondary to  
15 the manpower needs of the hospital where the school is  
16 located. We hastento point out that this does not occur  
17 in all cases. Reluctantly, we accept the fact that it  
18 does in many, to the detriment of the educational process.  
19 The financing of nursing education should conform to the  
20 methods long accepted in the financing of education for  
21 other professional groups.

22 A graduate registered nurse is a profes-  
23 sional person with professional skills at her disposal.  
24 She works in a profession that is short of such skills.  
25 It will be apparent, therefore, that any non-professional  
26 use made of these skills reduces the time available to the  
27 nurse to practise her special skills. Specifically, when  
28 a professional nurse is required to do work which a non-  
29 professional worker can and should do, this merely has  
30 the effect of reducing the professional nursing time





1 available. Specifically, if 100 nurses are each required  
2 to devote 30% of their time to non-nursing duties, the  
3 net professional nursing time available is that of 70  
4 rather than 100 nurses.

5 Similarly, poor design and layout of  
6 hospitals and other agencies where nurses are employed  
7 diminishes the time available for the application of  
8 professional nursing skills. Thus, if a hospital employ-  
9 ing 100 nurses is so designed that each nurse spends 10%  
10 of her time making trips to inconveniently-placed sources  
11 of supplies, the net effect is to reduce the effective  
12 use of professional skills from 100 nurses to 90 nurses.

13 It is the opinion of the Canadian Nurses'  
14 Association that the proper use of professional time offers  
15 one of the most rewarding opportunities for combating the  
16 increasing shortage of nurses felt throughout Canada  
17 today. It is the opinion of the Canadian Nurses' Associa-  
18 tion that nursing service will submit to the rules of effi-  
19 ciency and work simplification to the same extent as other  
20 forms of endeavour.

21 With further reference to the availability  
22 of nursing skills in Canada, the Canadian Nurses' Associa-  
23 tion suggests that vigilance be exercised to make certain  
24 that no deterrents are placed in the way of married  
25 registered nurses who are prepared to continue the prac-  
26 tice of their profession.

27 The atmosphere in which nurses work  
28 affects the numbers of students who enter the profession  
29 each year, the amount of professional skill available in  
30 the country, and the final standard of the service







1 rendered. This atmosphere includes all forms of working  
2 conditions, i.e. hours of work, remuneration, benefits,  
3 job satisfaction and old-age security. Devoted as nurses  
4 may be to their profession, it is unrealistic to assume  
5 that the flow of students will continue undiminished if  
6 the standards in this area are not comparable to those  
7 available to people with equivalent training in other  
8 fields of endeavour. It is not possible to assess the  
9 numbers of potential students who might be deterred from  
10 entering any profession because of the rewards which it  
11 does or does not offer. It is impossible, however, to  
12 estimate the number of nurses lost to Canada because of  
13 attraction to the United States. Statistics indicate  
14 that in 1960 1,372 Canadian-born and Canadian-educated  
15 nurses left to follow their profession in the United  
16 States (Appendix IV - Emigration of Graduate Nurses to  
17 U.S.). Admittedly, some return but the loss is still  
18 great.

19 Salaries are not believed to be the only  
20 factor behind the movement of Canadian nurses to the  
21 United States. Other attractions are the greater oppor-  
22 tunities in post-basic training and the wider scope of  
23 work and of research done.

24 In this connection we would point out  
25 that the Canadian Nurses' Association is concerned to  
26 extend the post-graduate study facilities available in  
27 Canada; this would mean increasing the number of nurses  
28 holding degrees that are already available here - i.e. up  
29 to and including the Master's. In addition, it would  
30 mean broadening the post-graduate field to include more





1 subjects and extending it to include the Doctoral level.  
2 As well as retaining nurses who go to the United States  
3 for study and, subsequently, remain to work, well prepared  
4 leaders would be provided for nursing education programs  
5 and top positions in administration and research in  
6 nursing.

7 One of the profession's responsibilities  
8 is to add to the body of its knowledge. The Canadian  
9 Nurses' Association believes that nurses  
10 should conduct more research and experimentation in  
11 patient care, nursing education and the administration  
12 of nursing service.

13 The nursing profession's concern in  
14 research has for its ultimate objective the patient's  
15 well-being. This does not mean that nurses are abdicating  
16 bedside care. Quite the contrary, nurses are jealous of  
17 this function of giving direct care to patients and wish,  
18 in every way possible, to improve and enhance it. As  
19 well, nurses see as their function a unique role in all  
20 health programs - in homes, in schools, in industry, and  
21 wherever people live and work - during the entire span  
22 of life of each individual.

23 Most health services are co-operative  
24 ventures carried on by members of several vocations.  
25 The Canadian Nurses' Association believes that in running  
26 the venture each group should have a voice that is commen-  
27 surate with its responsibilities.

28 It is also the opinion of the Canadian  
29 Nurses' Association that there is a need and an oppor-  
30 tunity for co-ordinated planning of all health services







1 in Canada. In the opinion of the Association, this  
2 could best be provided by advisory boards operating on  
3 regional and national levels, with the ability to provide  
4 educated judgment and reasoned, unbiased advice.

5 Nursing service is essential to adequate  
6 health services. The nursing profession in Canada is  
7 anxious to make its maximum contribution to this objec-  
8 tive.

9 RECOMMENDATIONS

10 Recommendation I

11 That a clear differentiation be made  
12 between nursing and medical activities, and

13 That transfer of activities be made only  
14 after study and agreement by all concerned. Special  
15 consideration should be given to the legal implications  
16 with regard to medical practice both for the safety of  
17 the patient and the protection of the nurse.

18 Recommendation II

19 That advisory committees on health  
20 services be established at regional and national levels  
21 to provide for co-operative and co-ordinated planning and  
22 that these committees include representation from the  
23 appropriate professions.

24 Recommendation III

25 That a study be made of the nursing  
26 requirements for all health services and the categories  
27 of personnel required to meet the nursing needs as effi-  
28 ciently and economically as possible. Having differen-  
29 tiated their functions, the education of the groups should  
30 then be developed accordingly.







1 Recommendation IV

2 That mental hospitals be encouraged to  
3 enlarge and extend their teaching programs to include,  
4 through affiliation, experience in psychiatric nursing  
5 for all nursing students, and further recommends

6 Recommendation V

7 Conditions of work and salary schedules  
8 be such that professional nurses will be encouraged to  
9 seek employment in mental institutions. Where these  
10 institutions exist in less accessible areas, personnel  
11 policies provide the necessary incentive to attract well  
12 qualified personnel.

13 Recommendation VI

14 Governments at all levels be encouraged  
15 to provide nurse consultants to work with Directors of  
16 Nursing in hospitals and public health agencies and with  
17 teachers of nurses to help orient nurses to the care of  
18 the mentally ill and incorporate the principles of mental  
19 health into all nursing programs.

20 Recommendation VII

21 That in the planning, construction and  
22 equipping of facilities for patient care the nursing  
23 personnel be consulted.

24 Recommendation VIII

25 That the Director of Nursing have the  
26 responsibility and authority

27 To plan the nursing care program and  
28 outline the budget

29 To obtain nursing staff and control all  
30 who provide nursing service





1 To account directly to the administrator  
2 and the governing board for the program  
3 for which she is responsible.

4 Recommendation IX

5 That in the provision of health services  
6 the functions and activities of nursing personnel (as  
7 well as that of other personnel) be clearly defined.

8 Recommendation X

9 That governments and other employing  
10 agencies recognize that basic education in nursing  
11 prepares nurses for beginning positions only and that  
12 further education is necessary to prepare expert nurse  
13 practitioners, head nurses, supervisors, teachers and  
14 senior administrative personnel, and

15 That having acquired advanced prepara-  
16 tion they be accorded recognition, authority and remunera-  
17 tion in line with their responsibility.

18 Recommendation XI

19 That graduate programs in universities  
20 should develop rapidly to prepare nurses in administration,  
21 clinical nursing, consultation and research.

22 Recommendation XII

23 That the education of nurses be under  
24 the jurisdiction of institutions whose primary function  
25 is education.

26 Recommendation XIII

27 That a cost study of present nursing  
28 education programs be undertaken to determine indirect  
29 as well as direct costs of the preparation of nurses.







1 Recommendation XIV

2 That financial aid be made available to  
3 all students who need assistance both prior to and during  
4 the basic nursing education program.

5 Recommendation XV

6 That financial aid be provided to assist  
7 universities to develop Schools of Nursing and enable  
8 existing university schools to expand, in order to provide  
9 basic preparation of nurses and also preparation at the  
10 graduate level.

11 Recommendation XVI

12 That remuneration for nurses reflect the  
13 value of their services to society and that salary scales  
14 should be commensurate with education, qualifications,  
15 responsibilities and duties.

16 Recommendation XVII

17 Financial incentives should be provided  
18 to encourage qualified nurses to assume the responsibili-  
19 ties involved in leadership positions.

20 Recommendation XVIII

21 That government and other employing  
22 agencies recognize that the organized profession has the  
23 right and the responsibility to exert reasonable control  
24 over the socio-economic welfare of its members including  
25 remuneration and conditions of work.

26 Recommendation XIX

27 That nurses be provided with superannua-  
28 tion benefits on an employer-employee basis and

29 That where such plans do not presently  
30 exist consideration be given to the adoption of the





1 Canadian Nurses' Association retirement plan.

2 Recommendation XX

3 That the principles of portable pensions  
4 be encouraged.

5 Recommendation XXI

6 That the provinces be urged to establish  
7 licensure for all who nurse for hire.

8 Recommendation XXII

9 That the Royal Commission on Health  
10 Services for Canada support a study to determine the  
11 quantity and quality of nursing care required by patients  
12 with different medical and dependency needs and in varying  
13 situations so that reliable up-to-date information will  
14 be available.

15 Recommendation XXIII

16 That Federal Government sponsor a  
17 research project in the administration of hospital  
18 nursing service in order to determine the factors both  
19 measurable and intangible which result in effective  
20 administration.

21 Recommendation XXIV

22 That a National Co-Ordinating Council  
23 on Health Reserach be established and supported by  
24 federal funds to seek ways of improved planning and  
25 co-ordinating of health services, and

26 That in setting up this Council represen-  
27 tation from the various professional groups contributing  
28 to health services be included.

29 Thank you very much, Mr. Chairman.

30 COMMISSIONER GIRARD: Mr. Chairman,





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TORONTO, ONTARIO

Carpenter

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1  
2 Miss Carpenter, I would like to say at the beginning  
3 that any questions that I will direct to you, you may  
4 in turn be free to call upon any of your colleagues to  
5 answer them.

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1 MISS CARPENTER: Thank you. Our plan is  
2 that any members of the panel may answer questions.

3 THE CHAIRMAN: And may remain seated while  
4 doing so.

5 COMMISSIONER GIRARD: We will start at page  
6 13, on the first recommendation:

7 "That a clear differentiation  
8 be made between nursing and medical  
9 activities, and that transfer of  
10 activities be made only after study  
11 and agreement by all concerned.  
12 Special consideration should be  
13 given to the legal implications  
14 with regard to medical practice  
15 both for the safety of the patient  
16 and the protection of the nurse".

17 I would like to start out by congratulating  
18 you, because I think this is something new, that has  
19 not come out in any of the other briefs we have had  
20 from provincial nursing associations so far, and I  
21 am sure we all agree that this is long overdue.  
22 Would you, Miss Carpenter, or any of the others, have  
23 in mind a plan, or criterion that could be used in  
24 this transfer of activities, or have you thought of  
25 any way in which this could be implemented?

26 MISS CARPENTER: I think at the provincial  
27 level we have already seen some provincial nurses'  
28 associations having discussions with the appropriate  
29 medical group, and sometimes they have come up with  
30 expedient solutions of the problem, and we still feel





1 that there is a need to consider this very carefully,  
2 because of the dangers involved in transferring some  
3 activity from the medical to the nursing group. Miss  
4 Campion is very close to it and may have some comment.

5 MISS CAMPION: Mr. Chairman, Miss Girard,  
6 there has been considerable concern as I have moved  
7 across the country concerning such functions as the  
8 administration of anaesthetics, the administration of  
9 intravenous medications, and other activities that  
10 have been turned over to the nurses, such as the  
11 removal of sutures and clips. There is considerable  
12 concern regarding nurses performing these functions  
13 when they have not been adequately prepared for them,  
14 and when they are still considered medical practice,  
15 and which the doctors say are still medical practice,  
16 but if there are no medical personnel, nursing may  
17 undertake these functions, and we really need some  
18 clarification.

19 COMMISSIONER GIRARD: Dr. Baltzan would like  
20 you to spell out some of these things, you mentioned  
21 the administration of anaesthetics and the administration  
22 of intravenous medications.

23 MISS CAMPION: Yes, particularly the  
24 administration of anaesthetics, the administration of  
25 intravenous medications.

26 COMMISSIONER BALTZAN: I was thinking of  
27 the taking of samples of blood.

28 MISS CAMPION: Yes.

29 THE CHAIRMAN: Blood transfusions, blood  
30 donations.







1 MISS CAMPION: I don't think that nurses in  
2 general are allowed to give blood transfusions, although  
3 in some places they are, and that is of course again  
4 a function which you would question as a nursing function.

5 COMMISSIONER GIRARD: Is the question here  
6 that you don't mind nurses taking on these functions, but  
7 you do want these functions to be defined and an official  
8 agreement made between the medical profession and the  
9 nursing profession that these things be done, or is it  
10 the opposite?

11 MISS CAMPION: No, we feel that with the  
12 shortage of nurses, and nurses being asked to undertake  
13 additional activities from the medical profession, it is  
14 reducing the time available for the actual nursing  
15 functions, and we are not sure that this is in the best  
16 interests of either the nursing profession or the  
17 patient.

18 THE CHAIRMAN: Do you reject that under proper  
19 safeguards that these functions are nursing functions?

20 MISS CAMPION: Well, if it is still considered  
21 medical practice --

22 THE CHAIRMAN: I mean apart from that type  
23 of discussion. I mean, provided that was out of the way?

24 MISS CAMPION: Well, if we were not short of  
25 nursing skills to perform what we feel are the most  
26 essential functions of nurses, then I see no reason why.  
27 We know nurses carry out these functions quite satisfact-  
28 orily. It is a question of the amount of nursing  
29 skills available.

30 THE CHAIRMAN: I suppose you are accepting





1       them because there was a shortage in the other field?

2               MISS CAMPION: Yes, and I feel we need fairly  
3       frank and open discussion between all concerned as  
4       to what is medical practice and nursing functions.

5               THE CHAIRMAN: Perhaps Mr. Henderson, I don't  
6       know if you have any views on it? What is medical  
7       practice, of course, is defined by the provincial  
8       statutes.

9               MR. HENDERSON: Yes, I don't have any particular  
10      comment, except that it is a problem of numbers and  
11      capabilities from a practical standpoint, but the  
12      submission, as I appreciate it, is that there should be  
13      a definition by legislation, through the provincial  
14      legislatures, to define clearly the areas where the  
15      nurse will be within the control of the hospital, where  
16      she will be within the control of a doctor, or where  
17      she will be within her own province, exercising her own  
18      clearly defined, proper functions. As I see it, there  
19      are these three areas in which she must work, either  
20      under the control of the doctor in the operating theatre,  
21      under the control of the hospital authorities in her  
22      routine duties, or on her own in providing direct care.  
23      It is the gray areas between these three that the nurses  
24      would like to have defined, either by agreement with the  
25      particular groups concerned, or through legislative  
26      action.

27              COMMISSIONER BALTZAN: If such a thing  
28      were promulgated through hospital regulations, the  
29      nursing representatives, and the director of staff, would  
30      that hold water?







1 MR. HENDERSON: Well, it perhaps has the  
2 advantage of flexibility. I am not answering your  
3 question as to whether it would hold water. I don't  
4 see any legal problem arising, or any legal implications  
5 arising from such an arrangement. It would seem to me  
6 to be a loose arrangement, which would be effective,  
7 but not standardized, because it would depend entirely  
8 on what specific arrangement would be made at a  
9 particular location.

10 COMMISSIONER BALTZAN: Would it protect the  
11 nurse?

12 MR. HENDERSON: In that location, but it is  
13 not general enough to attain what the Nurses' Association  
14 is seeking. It would appear to be on an ad hoc basis,  
15 depending on the needs of a particular location, at a  
16 particular time.

17 COMMISSIONER BALTZAN: This is so often the  
18 case in smaller hospitals.

19 MR. HENDERSON: Yes, but I am sure that that  
20 is the intent behind this submission. As I appreciate  
21 it, it is to define the functions with some reasonable  
22 degree of precision, and I don't think that would happen  
23 on the individual basis you suggest. Maybe within  
24 the larger framework these arrangements can be made.  
25 Now, I have said a great deal without being absolutely  
26 certain that I am expressing clearly the intent of the  
27 Association.

28 COMMISSIONER BALTZAN: You are very clearly  
29 helping our thinking. Medical staffs have found nurses  
30 most competent. They do better medical histories than







1 a lot of interns. Has the nursing profession any  
2 objection, or would they feel that they would like to  
3 cooperate in that effort, because they are dependent  
4 on many areas?

5 MISS CAMPION: Mr. Chairman, Dr. Baltzan, we  
6 have no objection to the hospitals employing nurses to  
7 carry out any of these functions if they are employed  
8 in this capacity, but the trouble arises when they are  
9 withdrawn from the quota of nurses giving nursing care  
10 to undertake these functions. We would regret seeing  
11 nurses being withdrawn from the profession, because we  
12 have a shortage of nursing skills, and the taking of  
13 medical histories, we feel, is not ---

14 MISS CARPENTER: One point we should raise  
15 from the point of view of the education of the nurses,  
16 regarding this recommendation. If we continually do  
17 functions from the medical practice, one area  
18 in relation to one of your former questions is the  
19 safety in patient care. If the nurse is not trained  
20 and qualified, and does not understand some of the  
21 implications of the things she is doing, and the most  
22 pronounced example is the giving of anaesthetics, I  
23 believe the Association would feel that this is not  
24 safe practice.

25 THE CHAIRMAN: Unless there is prior training.

26 MISS CARPENTER: Yes, right now we are having  
27 trouble in the educational field, and to add these areas  
28 of preparation to the depth that they should be added,  
29 a submission on Friday was raising some of these questions,  
30 would perhaps make it undesirable for this practice to





1 be done at the present time, or in the near future.

2 THE CHAIRMAN: I think Mr. Henderson would  
3 agree that anybody involved, whether a nurse or anybody  
4 else purports to do something that requires special  
5 skill, that person must in fact possess the skill and  
6 if by reason of not possessing it something goes wrong,  
7 there is individual liability, and therefore we are  
8 right back to the question of training, that they must  
9 be trained before they can be asked, or before they  
10 should individually accept the responsibility of doing  
11 some of these acts.

12 MISS CARPENTER: Yes.

13 MR. HENDERSON: That poses the problem when  
14 the nurse is under the control of somebody else and  
15 directed to do an act where she may not possess the  
16 qualifications. This is one area where the line  
17 of demarcation should be clearly defined, because she  
18 may be directed to do a job which involves legal  
19 implications to her, as well as to the institution  
20 employing her.

21 COMMISSIONER GIRARD: There is at the present  
22 time a Joint Committee of which the Canadian Nurses'  
23 Association is a member, with the Canadian Medical  
24 Association, and the Canadian Hospital Association.  
25 Would you see such a committee working on this?

26 MISS CARPENTER: I think such a Committee  
27 could take an interest in it at the national level. I  
28 think it needs to be discussed, and hammered out so  
29 to speak, at the provincial level and the local level,  
30 and I know it has been the hope of the National Committee







1 that the Canadian Joint Committee on nursing, represent-  
2 ing the three interested groups, hospitals, medical,  
3 and nursing, that such joint committees be developed at  
4 the provincial level, and perhaps this will come as  
5 the result of some of these discussions that we are  
6 having at this time with the Commission.

7 MISS MacLENNAN: It has been in my mind on  
8 differentiation of duties, if it were to come about  
9 that these functions, the giving of anaesthesia,  
10 intravenous therapy, and the removal of sutures, and  
11 this, if they were to be identified as nursing activities,  
12 then would the intern group, the medical group, retire  
13 entirely from that field? Would they become nursing  
14 duties assigned in the training of nurses as procedures?  
15 When would it be a medical duty, and when a nursing  
16 duty if it were going to be recognized as a justified  
17 nursing procedure?

18 COMMISSIONER GIRARD: Maybe some of the  
19 physician members of the panel would like to ---

20 THE CHAIRMAN: I thought our new Dean of  
21 Nursing would.

22 COMMISSIONER GIRARD: Well, I think it is a  
23 subject that needs to be discussed thoroughly, and I  
24 think the sooner the two professions will get together  
25 on this, the better it will be for everyone.

26 On recommendation No.II, page 13:

27 "That advisory committees on  
28 health services be established at  
29 regional and national levels to  
30 provide for co-operative and co-





1           ordinated planning and that  
2           these committees include  
3           representations from the appropriate  
4           professions".

5           I believe you mean that this Advisory Committee  
6           should be established now, or does it mean that in the  
7           event of government insurance plans that this ---

8           MISS CARPENTER: Mr. Chairman, if I may  
9           answer Miss Girard. I would think that we have seen  
10          a need for such committees to exist now in this period  
11          of rapid expansion of hospital services, primarily with  
12          the Canadian prepaid hospital care.





1 We would hope that such committees  
2 might be stimulated to become available and would bring  
3 the profession more closely together as a result too of  
4 this enquiry when we have had an opportunity to bring  
5 out the need of such co-ordinated planning.

6 COMMISSIONER GIRARD: When you say  
7 "regional" do you mean professional or on a smaller  
8 basis or smaller regions - provincial, I am sorry?

9 MISS CARPENTER: Well, I think we  
10 could see such committees working at the provincial and  
11 perhaps at the municipal level. In certain areas where  
12 the municipalities are rather large it would depend a  
13 lot on the internal workings in the different provinces  
14 and, of course, this differs from province to province.

15 COMMISSIONER GIRARD: Would you have  
16 any opinion of by whom could these advisory committees  
17 be established?

18 MISS CARPENTER: Well, I do not know  
19 whether anybody else would like to answer but I think  
20 we have seen such committees established by government;  
21 we have the Dominion Council of Health at the federal  
22 level; the Deputy Minister of Health might like to set  
23 up committees especially on an advisory basis or the  
24 Deputy Minister of Health or, at the present time, the  
25 Hospital Commission, it may be they would be established  
26 under voluntary groups through organizations such as  
27 welfare councils and social planning councils and so on.

28 We do have some such committees but,  
29 again, perhaps they could be used more effectively than  
30 they are and we could give more concerted effort to this







1 kind of planning.

2 COMMISSIONER GIRARD: On page 15,  
3 Recommendation III:

4 "That a study be made of the nursing  
5 requirements for all health services  
6 and the categories of personnel  
7 required to meet the nursing needs  
8 as efficiently and economically as  
9 possible. Having differentiated their  
10 functions, the education of the groups  
11 should then be developed accordingly."

12 When you say "a study be made", would  
13 you like to say by whom?

14 MISS CARPENTER: Well, this is an area  
15 in which the Canadian Nurses' Association has been  
16 concerned. As you may recall, the result of our pilot  
17 project on nursing education brought out the fact that  
18 there is a need to study further the field of nursing  
19 education and we have felt at this time when nursing  
20 care is fitting into a society that is so much more  
21 complex and health needs are changing in that way, the  
22 citizens are going to meet these health needs is under  
23 discussion and review that it would be well to first  
24 look at nursing requirements for health services and  
25 look at the possible categories of personnel before  
26 deciding on our recommendations.

27 We, as an Association, have been nego-  
28 tiating with Professor Negele of the University of British  
29 Columbia to undertake a study of this kind; whether he  
30 could cover this whole broad field or whether it would





1 need assistance from a body such as your own or the  
2 Government, this is something that might be considered.

3 COMMISSIONER GIRARD: When you read  
4 the previous paragraph:

5 "The Canadian Nurses' Association  
6 therefore believes that nursing service  
7 needs can best be met through the  
8 consolidation of the current categories  
9 of nursing and personnel into fewer,  
10 possibly two, groups which can be  
11 differentiated on the basis of functions  
12 and education and recommends -"

13 And you go on to Recommendation III. Could we gather  
14 from this that you would want to embark on this study  
15 with a blank mind, let us say, and in taking into consi-  
16 deration what would seem to have made up a logical out-  
17 come and this is the two groups?

18 MISS CARPENTER: Well, I think this  
19 arises and we are very conscious of this in this panel  
20 because it has got a good deal of discussion in our  
21 executive. We are very conscious of the number of  
22 people that now participate in nursing and we know from  
23 our own nursing experience the difficulty that results  
24 from what we consider a proliferation of the nursing  
25 care needs of people so various grades of personnel may  
26 participate.

27 We get overlapping, we get gaps and the  
28 patient very often does not know who his nurse is. We  
29 feel very keenly it would be desirable to have less  
30 persons participating in nursing care and some of us







1 believe, without this study, that perhaps two groups  
2 could do it; others believe it would take more than  
3 that so we are really at the place of not knowing.

4 A great deal, of course, will depend  
5 on the developments in health services; are we going to  
6 have methods of in-patient care or out-patient care and  
7 home care and all these developments in the health field  
8 will have their impact on nursing and how we should plan  
9 to improve nursing care of the people. I think this  
10 study would help to see the demand of the future, the  
11 foreseeable future and the categories of personnel,  
12 the need for nursing care of the people.

13 COMMISSIONER GIRARD: If, as a result  
14 of that study, a report came out setting out four or five  
15 different categories, would the Canadian Nurses' Associa-  
16 tion be happy about that or would they not or would they  
17 implement it or would they feel they are not bound to  
18 implement the study?

19 MISS CARPENTER: Perhaps I should ask  
20 the President-Elect because she will be the President  
21 at the time the report comes out.

22 MISS MacLENNAN: In answer to that,  
23 this is another of the \$64,000 questions that I would  
24 not presume to answer. I do feel we should not have too  
25 rigid a mind in the beginning of the study. Presuming  
26 we are going to talk in terms of two types or two cate-  
27 gories, that would be cutting us off in the beginning of  
28 the study. If the result of the study should bring forth  
29 that there is a need for three or four or even five  
30 categories of professional personnel then we would have





1 to look very carefully at what the study recommends in  
2 the areas of these various categories of the work and  
3 see if we could possibly agree. We may have blind spots  
4 to it that will be enlightened if a survey is done and  
5 the plan would be very logical.

6 On the other hand, it may be what they  
7 set up as the areas of work for five categories we would  
8 not consider to be logical and, therefore, we would take  
9 it to the Executive and see what could be done about it.

10 COMMISSIONER GIRARD: Even if the report  
11 said we should have a category of work in the profession  
12 that the medical profession will pass on down to us?

13 MISS MacLENNAN: Of course, the medical  
14 profession would have a little say in that too.

15 COMMISSIONER McCUTCHEON: Are you saying  
16 in effect that when I ring the bell I ought to know who  
17 is going to come into my room?

18 MISS CARPENTER: I think that on each  
19 8-hour shift you ought to know the nurse looking after  
20 you; in those 8 hours she may delegate some of the  
21 responsibility to assist in various ways but I think  
22 every patient should know the registered nurse who is  
23 professionally responsible during that period. Who is  
24 looking after their needs and should be able to discuss -  
25 should be able to discuss with that nurse any care you  
26 feel you do need or any problem you have during that  
27 period.

28 She should be responsible for passing  
29 on your nursing care needs to the next nurse.

30 COMMISSIONER McCUTCHEON: To the next





1 shift?

2 MISS CARPENTER: Yes.

3 COMMISSIONER GIRARD: On page 16, para-  
4 graph 57:

5 "Despite a favourable ratio of nurses  
6 to population in comparison with other  
7 countries, there is a shortage of  
8 nursing services in Canada both in  
9 quantity and quality."

10 Then this refers us to Appendix 2 of  
11 the International Labour Association on employment and  
12 conditions of work of nurses.

13 Appendix 2 gives us the estimated  
14 numbers of professional nurses to population and also  
15 the ratio of auxiliary and because you mention here  
16 quantity and quality I presume that quantity is easy to  
17 understand and I assume that quality here refers to  
18 ratio of registered nurses to auxiliary personnel. Is  
19 that it?

20 MISS CARPENTER: Well, I think it refers  
21 to the general discussion that we receive the general  
22 information, we receive from the public, the hospital  
23 administrators, doctors; amongst our own selves we are  
24 not happy about the quality of nursing care we are able  
25 to give.

26 I think it may be, I would think one  
27 factor is the ratio which I gather, particularly in  
28 Alberta, is extremely disquieting to the auxiliary  
29 personnel; I believe other factors enter into it.

30 COMMISSIONER GIRARD: Then is it the







1 quantity and quality? This table gives us the quantity  
2 and ratio so I wondered whether you associated ratio  
3 with the quality since you referred us to this table  
4 and have mentioned quality. It was just to clarify this.

5 Also on page 17, this is not a recommen-  
6 dation but again in paragraph 60 you say:

7 "This situation is improving very  
8 gradually."

9 I think you are referring to the shor-  
10 tage of registered nurses in psychiatric hospitals and  
11 so on:

12 "This situation is improving very  
13 gradually. The ratio of graduate  
14 nurses to patients in mental hospitals  
15 has increased from 1.64:5 in 1930  
16 to 1.58:4 in 1960."

17 The point is the ratio of graduate  
18 nurses to patients. Do you mean graduate registered  
19 nurses or registered nurses plus psychiatric nurses  
20 because psychiatric nurses may be graduate nurses too;  
21 what do you mean?

22 MISS STIVER: This is the graduate  
23 registered nurse.

24 COMMISSIONER GIRARD: Thank you. Then,  
25 paragraph 61:

26 "Provincial nurses' associations  
27 recommend that schools of nursing  
28 include psychiatric nursing in the  
29 curriculum, with a period of clinical  
30 experience in a psychiatric hospital."





1 The next sentence is what I am questioning:

2 "Only one province - Newfoundland - has  
3 this as a requirement for nurse registra-  
4 tion."

5 I think there is a matter of a little  
6 omission and the little omission is La Province de Quebec.

7 MISS STIVER: Pardonnez-moi.

8 COMMISSIONER GIRARD: It is three years  
9 since the Province of Quebec Association has not given  
10 a licence to any student that has not had three months  
11 of affiliation in psychiatry.

12 MISS CARPENTER: We stand corrected.

13 COMMISSIONER GIRARD: This is evidence  
14 we did not get together on this brief, Mr. Chairman.

15 On page 17, Recommendation V:

16 "Conditions of work and salary  
17 schedule be such that professional  
18 nurses will be encouraged to seek  
19 employment in mental institutions."

20 When you say "professional nurses",  
21 again, to whom do you refer? If I remember rightly  
22 psychiatric nurses that have had a three-year course in  
23 some of the western provinces were referring in their  
24 brief to their profession so as far as they are concerned  
25 they are professional nurses.

26 When you say "professional nurses" to  
27 whom do you refer?

28

29

30







1 MISS STIVER: We are referring to the  
2 registered nurses.

3 THE CHAIRMAN: In this brief you are purporting  
4 to speak for your own organization?

5 MISS STIVER: Yes.

6 COMMISSIONER GIRARD: I hope so. I think  
7 sometimes we have to clarify these things because it  
8 is not always clear when you hear the stories from the  
9 two groups.

10 COMMISSIONER BALTZAN: Not very clear right  
11 here. May I ask: psychiatric nurses go in straight  
12 to psychiatric nursing for three months or three years  
13 without basic training in regular courses of the  
14 registered nurses, therefore they become either a  
15 psychiatric nurse's aid or graduate psychiatric nurse?  
16 I don't know.

17 MISS CARPENTER: I am not quite clear -- The  
18 question is: if a nurse goes right into ---

19 COMMISSIONER BALTZAN: I will try to make it  
20 simpler. Can some person enter into the study of  
21 psychiatric nursing in one of two categories, that is  
22 psychiatric nurse's aid or psychiatric nurses graduate  
23 without having the basic training for, or as a resigered  
24 nurse?

25 COMMISSIONER GIRARD: I believe Dr. Baltzan  
26 is referring to this three months psychiatric study,  
27 this is an affiliation which the student nurses during  
28 their three year course, have to take this affiliation.

29 COMMISSIONER BALTZAN: That I accept and  
30 understand.





1 MISS CARPENTER: There are groups of nurses  
2 in, I believe, I might be corrected on this, I believe  
3 the three western provinces that have an arrangement  
4 whereby the hospital admits these students to what  
5 they call a school of nursing in which they undertake  
6 to prepare this student for psychiatric nursing only and  
7 they are not then eligible for registration as a  
8 registered nurse because they have no general training,  
9 but they are qualified to nurse psychiatric patients  
10 only and this is a trend which we have tried to avoid  
11 having in this country. It is quite common in some  
12 other countries.

13 THE CHAIRMAN: The Commission will remember  
14 the complaint we had from these people in Alberta.  
15 They were excluded from the stream of nurses.

16 COMMISSIONER McCUTCHEON: They can tie in  
17 only to a mental institution. No place else.

18 MISS CARPENTER: Is the question in relation  
19 to this nurse would then have to qualify as a registered  
20 nurse if they wanted to nurse in other areas, and if  
21 the registered nurse, who has had her affiliation in  
22 a psychiatric hospitals wishes to specialize in  
23 psychiatric nursing and take graduate preparation, she  
24 is free to do so.

25 We do have a group of students in our  
26 University schools of nursing undertaking special studies  
27 in these fields but the other group, unfortunately, the  
28 psychiatric hospitals have admitted students with less  
29 educational qualifications. Then generally they have  
30 not sufficient academic background to undertake the





1 graduate nursing courses that are available.

2 In Ontario, one of the provinces that has  
3 worked with this problem, it has been possible to keep  
4 the admission standard in the schools run by  
5 the psychiatric hospitals at the same level as the  
6 standards of the other general hospitals and to arrange  
7 an affiliation during the period of psychiatric nurse  
8 preparation in the general hospital so these nurses  
9 in Ontario that graduate from schools in mental hospitals  
10 are eligible for registration as a registered nurse.  
11 This level, of course, is the more desirable approach  
12 to this problem.

13 COMMISSIONER BALTZAN: You say that these  
14 people meet a current need but they do not meet your  
15 standards.

16 MISS CARPENTER: You mean the people that  
17 train in the psychiatric hospitals only?

18 COMMISSIONER BALTZAN: Yes. Go off  
19 on a tangent to learn one subject well.

20 MISS CARPENTER: I think many of the  
21 psychiatric hospitals are very happy to have them.  
22 Again I think one has to recognize that as a whole  
23 in relation to nursing education, this is expedient.  
24 The hospital has established this school because they  
25 have a primary responsibility for service. They have  
26 not been able to meet the needs of service and so as  
27 an expedient measure to get service they have undertaken  
28 the training of their own personnel. If those people  
29 will work in those hospitals, they have trained  
30 personnel on the job. Once those graduates want to







1 leave and work in a general field, they lack the  
2 preparation although they have given a good many years  
3 to their training and it is unfortunate for the graduates  
4 from these schools, but it is probably not unfortunate  
5 for the mental hospital who has an assured staff as  
6 a result of their training program.

7 COMMISSIONER GIRARD: On page 18, recommendation  
8 six:

9 "Governments at all levels  
10 be encouraged to provide nurse  
11 consultants to work with directors  
12 of nursing in hospital and public  
13 health agencies and with teachers  
14 of nurses to help orient nurses  
15 to the care of the mentally ill  
16 and incorporate the principles of  
17 mental health into all nursing  
18 programs".

19 Would you think that this would be a  
20 Government or would you not prefer to have in the  
21 schools of nursing a nurse specialized in psychiatric  
22 nursing that would also be with the staff all the time  
23 instead of a consultant away up on the federal level  
24 or on the provincial level that would only come in  
25 once in a while?

26 MISS CARPENTER: I would think Miss Girard  
27 that one does not exclude the other. We have had in  
28 our Province we have had a nurse consultant, for  
29 example, on the division of mental hospitals of the  
30 Department of Health. This individual has been able to





1 help schools to use the facilities of the mental  
2 hospitals in education of nurses. Generally has  
3 also been able to assist the hospital to develop a  
4 program for students that has been useful. I think  
5 that sometimes at the consultant level you can get  
6 working together if you have someone responsible for  
7 bringing them together and this nurse consultant I  
8 think might work in the field, in general, in the  
9 improvement of nurse services, nursing education as it  
10 relates to the preparation of nurses for mental health  
11 and psychiatric nursing care, but I think the schools  
12 too have, of course, to have an instructor on their  
13 staff who can incorporate these concepts of care of  
14 people. Not all mental illness, of course, is in  
15 psychiatric hospitals. You have patients suffering  
16 from deviations from normal mental health. The  
17 general hospitals more and more are having these  
18 patients.

19 COMMISSIONER GIRARD: This is why I think  
20 there should be one on the staff of every school  
21 program.

22 MISS CARPENTER: Yes, surely.

23 COMMISSIONER GIRARD: I do not want to exclude  
24 the one on the Federal level or on the Provincial level.  
25 I think the more we have the better it is. I think  
26 one on the Federal level with 171 schools did we say  
27 in Canada? Something like that.

28 MISS STIVER: Mr. Chairman, if I may add  
29 I think there was a thought here also of in-service  
30 educational programs for staff nurses as well as schools.







1 COMMISSIONER GIRARD: On page 24, recommendation  
2 11:

3 "That graduate programs in  
4 universities should develop rapidly  
5 to prepare nurses in administration,  
6 clinical nursing, consultation and  
7 research."

8 Personally I do not believe that this  
9 recommendation is forceful enough. I think when we  
10 say only universities should develop rapidly, we are  
11 not going far enough because I think there must be  
12 some reasons why universities are not developing more  
13 rapidly and should we seek those reasons and seek the  
14 cause and try to remedy the cause? Miss Carpenter may-  
15 be you would be able to speak on this.

16 MISS CARPENTER: I think Mr. Chairman there  
17 are several areas in which this development is  
18 certainly modified. One, of course, is finances.  
19 Universities have a very large expanding program in any  
20 case in all their schools. We have this increased  
21 population coming to universities. We have  
22 developments that demand new training and sometimes  
23 very extensive training in certain groups in universities  
24 and so we have to recognize that nursing schools are  
25 very small parts so far as the university nursing and  
26 we cannot expect to perhaps have a very large priority  
27 in relation to the total demand on the university.

28 So one problem is certainly financial aid.  
29 Another problem of course is securing nurses qualified  
30 to take these positions. When we start the development





1 of graduate programs, as we recognize by the most  
2 recent universities who have started these programs,  
3 one thing we have to do is set out to find qualified  
4 staff and very often send them away to get qualifications  
5 to undertake teaching at this level so that another  
6 area that makes for slowness in this development is  
7 the securing of qualified personnel.

8 I think in addition to my interest in this  
9 field we have Miss MacLennan's, Sister Madeleine's  
10 interest and perhaps others would speak to the problem  
11 of this development. We feel the need for it in  
12 Canada and I think we have seen this awakening interest  
13 and even development in it. I think it is three  
14 schools now, three universities in Canada who do have  
15 master level program. They are all in the beginning  
16 stage.

17 COMMISSIONER GIRARD: Going on to page 28, we  
18 are now in the section of education, and paragraph 94,  
19 starting paragraph 94 refers to current problems  
20 relevant to hospital schools. We go on in a few  
21 paragraphs to describe some of the shortcomings of  
22 hospital schools. There is only one little paragraph  
23 that I would like to bring up and that is paragraph  
24 95:

25 "Another problem is that  
26 teaching is concentrated in the  
27 first year rather than distributed  
28 through the entire course and  
29 related to practice."

30 I believe that the spotlight on nursing





1 education says that about 50 per cent of the courses  
2 are in the first year. If I am right, around 50  
3 per cent. Now I am not too sure that I agree with  
4 this. When I was a student, and that is a long long  
5 time ago, the whole curriculum was --all the grades  
6 were distributed in the three years and I think that  
7 if we have more in the first year now, I think it is  
8 an improvement and I think if we do teach more in the  
9 first year it is for the benefit of the students, not  
10 for the benefit of the hospital.

11 We are able now, after long periods of  
12 waiting, to be able to keep the student in the schools  
13 for a preliminary period of three months or four months  
14 and in those three months or four months we try to  
15 give her the basic teaching that she needs, such as  
16 anatomy, nursing arts, bacteriology, medicine and  
17 surgery, that she needs to have, and this is before  
18 she goes out into practice and the rest she should do  
19 and does as she goes into the different categories of  
20 work so I do not look upon this as something wrong.  
21 I look upon this somewhat of an improvement.

22 MISS CARPENTER: Mr. Chairman, if I may  
23 refer to -- I think we brought it with us, the pilot  
24 project. This is in the table on page 59 of that  
25 project is the table to which Miss Girard is referring.

26 Criteria were set up in order to evaluate  
27 these twenty-five hospitals schools of nursing. One  
28 of their criteria is item 3 in table 29 on page 59  
29 and the criteria was not more than 50 per cent of the  
30 total number of hours and the instruction should be in







1 the first year and we found that three schools had  
2 organized their curriculum in such a way that not over  
3 50 per cent of the total theoretical instruction given  
4 to the student was in the first year.

5 Now I think from the point of view of  
6 education and curriculum planning we have to remember  
7 that this is a three year course and so the student  
8 is going to be learning to nurse over a three year  
9 period and in general one hopes in a curriculum to be  
10 able to relate theory and practice so the student  
11 understands and she has the application of what they  
12 are practicing.

13 The more common, I suppose, illustration may  
14 be in a course in science, for example, where there is  
15 laboratory work planned and the laboratory work is  
16 related to the teaching in that particular time so  
17 that what we feel is that if the course is three years  
18 there must continue to be content beyond the first year  
19 and that if the student knows all this prior content  
20 before beginning the work, she must need the continuing  
21 content as she goes along or she may need repetition  
22 of this. There is theoretical instruction in classroom  
23 hours that are needed along with the practice throughout  
24 the three years of the course and the criteria here  
25 is that not more than 50 per cent in the first year.  
26 At least one-fifth of the hours of instruction are  
27 taught in the third year. This suggestion is that  
28 at least one-fifth of the total hours of instruction  
29 in the three year course may be in the final year and  
30 in those circumstances we found only two schools had





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1 their curriculum so arranged that there was one-fifth  
2 of the total instruction given in the final year of  
3 the course. Now most of us who are concerned with  
4 planning curricula do plan a course in which there is  
5 theory and practice in each year of the course. I  
6 think this is common in every educational program.







1 COMMISSIONER GIRARD: Miss Carpenter,  
2 I am not quarrelling on the percentage or on the amount,  
3 but I appreciate that it is important that the student  
4 needs more during the first year before she goes into  
5 the clinical areas.

6 MISS CARPENTER: I think she needs a  
7 great deal.

8 COMMISSIONER GIRARD: She needs to  
9 have some during the three years, and the amount, I  
10 wouldn't quarrel on the 50% or 40%, but I think there  
11 should be something before the student goes into the  
12 clinical areas; she needs to have more, and I think it  
13 is something basic the student needs before the student  
14 goes into them. I am not going to dwell too long on  
15 that; there are pros and cons.

16 After the hospital school we go back  
17 to the university school. In paragraph 91, page 27,  
18 you say:

19 "There are 17 schools of nursing in  
20 Canada associated with universities.  
21 Of these, 14 offer a basic course  
22 leading to a baccalaureate degree."

23 Now, there are 14 university schools  
24 giving a baccalaureate degree, and in paragraph 92 you  
25 say that six of the 14 offer basic degree courses compar-  
26 able to those offered by the universities to students in  
27 other professional courses.

28 Then you go on, in the following page,  
29 paragraph 93, to say:

30 "The remaining eight university schools





1 offer programs, usually five years in  
2 length, in which the university  
3 assumes responsibility for the first  
4 and fifth year. Responsibility for  
5 basic content in nursing is delegated  
6 to a hospital school."

7 So here we come into the area where  
8 the hospital school is not very good but some univer-  
9 sities are using the hospital school for their hospital  
10 training.

11 THE CHAIRMAN: Are you attempting the  
12 assumption that the hospital school is not very good?

13 COMMISSIONER GIRARD: No, but there are  
14 three or four schools here, and, on the other hand, eight  
15 of the 14 university schools are using hospital schools  
16 in their degree courses for the nurses. So I would like  
17 to have your comment or some of your colleagues' comment  
18 on this.

19 MISS CARPENTER: If I may comment on  
20 this and others may wish to as well. I think, without  
21 being facetious about it, there have been many grave  
22 weaknesses in the hospital school. As we come out with  
23 in this brief, we have given credit to the hospitals  
24 who have given out a good course, and I would want  
25 to preface the statement that hospitals in the 100 years  
26 in this country have trained its nurses and are still  
27 doing it.

28 But we do realize that the hospital's  
29 primary purpose is to give service, and the difficulty  
30 in getting nurses may be found in the difficulty in





1 getting qualified personnel, it may have limited budget,  
2 and the problem is to nurse the patients, and when the  
3 hospital has a school of nursing the hospital must nurse  
4 its patients.

5 If you deal with page 74 of the project,  
6 I think this table at the top of page 74 illustrates the  
7 concern we have as a profession, and all the citizens in  
8 Canada should have, and that the student nurses in some  
9 instances in 1960 were the only nurses on duty in a  
10 hospital during the night, and complete care of patients,  
11 the nursing care of patients in the night was sometimes -  
12 the staffing was 100% students and no registered nurses.

13 If this happens we have great concern  
14 that the quality of student education and the quality of  
15 service the patients get is not what it should be.

16 In the meantime, we did have four  
17 schools that had a desirable standard in an educational  
18 setting, and we have mentioned the difficulty of a univer-  
19 sity getting enough money for the nursing student, and  
20 I look upon the university school as an expedient measure  
21 to uplift the nursing education at this time, understand-  
22 ing that they don't have a budget in which the Faculty  
23 of the University have the complete control of the educa-  
24 tion of nurses.

25 In the school I came from we started in  
26 this way in 1929 to 1930, and when we gained experienced  
27 and were able to get quality staff we gradually changed  
28 so we provided teaching nursing throughout the four-year  
29 course. I think the University Faculties as well as the  
30 staff would like to see change come about.







1 I think that one of the factors that  
2 we are trying to point out is that this makes an unneces-  
3 sary long course for the students, they may be in five  
4 years when they could spend less time, and the student  
5 must leave the campus and not have the contact with  
6 university students.

7 So that many problems are apparent in  
8 such an arrangement, and I think it is unique and  
9 perhaps the University - I don't think any other profes-  
10 sion will grant a degree where the major subject has not  
11 been taught by the University.

12 It is rather unique to have the Univer-  
13 sity giving a degree in nursing where they don't have  
14 responsibility for planning and teaching nursing. How-  
15 ever, these practices exist, and as we know from our  
16 contact with these university schools, that they very  
17 carefully select the university to which their students  
18 may go; they select from the better schools, and this  
19 is an indication that there is recognition that some of  
20 the hospitals have been able to be good schools.

21 But its prime concern is for service.  
22 I think I have spoken rather lengthily on this point,  
23 but I think it is one that should be made clear.

24 COMMISSIONER GIRARD: I think you gave  
25 us a good answer to that, Miss Carpenter.

26 Page 32, Recommendation XIII:

27 "That a cost study of present nursing  
28 education programs be undertaken to  
29 determine indirect as well as direct  
30 costs of the preparation of nurses."





1                   Would you explain a little further what  
2 you think or what you mean by the "indirect costs"?

3                   MISS CARPENTER: Well, Mr. Chairman,  
4 Commissioner Girard, in the studies so far all the costs  
5 of nursing education in the hospital schools, the problem  
6 has been how much does the hospital use the student for  
7 service.

8                   The second problem is how much value  
9 can one give to that service, and this is one area of  
10 indirect costs. As you can see by the table at the top  
11 of the report, it is very difficult to assess those, and  
12 we think direct studies should be made.

13                   Another point is the costs that have  
14 gone into the building, in some cases, expensive recrea-  
15 tional facilities, and sometimes these are private facili-  
16 ties and they are not available to the students, and  
17 these indirect costs of the capital expense plus deprecia-  
18 tion of these are another area of indirect expense.

19                   COMMISSIONER GIRARD: Page 32 again,  
20 Recommendation XIV:

21                   "That financial aid be made available  
22 to all students who need assistance  
23 both prior to and during the basic  
24 nursing education program."

25                   When you say prior to , nursing assis-  
26 tance prior to, to what do you refer there?

27                   MISS CARPENTER: I have in mind, Mr.  
28 Chairman, the drop-out rate from high schools, and if  
29 by chance students are dropping out before completing  
30 their program because the family requires that they go







1 to work, it might be possible to begin to encourage  
2 young people to stay and continue their secondary educa-  
3 tion and go on to some high school course.

4 COMMISSIONER GIRARD: And then you say:  
5 "during the basic nursing education program". Do you  
6 mean any kind of educational program?

7 MISS CARPENTER: We wish to encourage  
8 more students to go into nursing, and particularly if  
9 in the future - and this may be a long-distance future -  
10 we are going to ask these students to have the same  
11 conditions as others in the community, they may not have free  
12 uniforms, board and free books - and they are not free,  
13 these things are paid out of our taxes - perhaps it  
14 would be better that the families who can support their  
15 own young people perhaps through a reasonable length of  
16 education, they can do that, and others get university  
17 bursaries which are available in other educational  
18 systems.

19 COMMISSIONER GIRARD: On page 38,  
20 Recommendation XXII:

21 "That the Royal Commission on Health  
22 Services for Canada support a study  
23 to determine the quantity and quality  
24 of nursing care required by patients  
25 with different medical and dependency  
26 needs and in varying situations so  
27 that reliable up-to-date information  
28 will be available."

29 I would like to point out one point -  
30 and I have pointed it out on several occasions in the





1 nursing brief to this Commission - the urgency of such  
2 a study. Would you like to speak more on it?

3 MISS CARPENTER: If I may, Mr. Chairman,  
4 ask one of the members to speak to this. I think it is  
5 one of the points of nursing service. If Miss Campion  
6 cares to comment on it or any other member of the panel.

7 MISS CAMPION: Mr. Chairman, Miss Girard,  
8 as you know, there are many requests for us to set up  
9 standards of staffing patterns, the number of hours of  
10 nursing care, and until we know more about the needs of  
11 patients, the type of care we could and should be giving  
12 to patients, what are the needs of patients - there is  
13 such a great variation in the amount and kind of care  
14 that patients need, and there is such a variation in  
15 the numbers and kinds of patients in any one ward and  
16 at any one time.

17 So you will have to have a great deal  
18 of flexibility in your staffing to meet the needs of  
19 patients. I think most people are conscious of the fact  
20 that the meeting of the so-called cycle needs of patients  
21 contribute to restoring and maintenance of health.

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1 That is they do depend a great  
2 deal on the emotional support. We don't know just how  
3 much of this really contributes to the welfare of  
4 patients.

5 COMMISSIONER GIRARD: Do you believe that  
6 this 3.4, 3.5 norm is still valid?

7 MISS CAMPION: Well, there are so many  
8 varieties that I think it is unrealistic to expect that  
9 to be valid in all circumstances. Your physical  
10 facilities, the preparation and qualifications of  
11 giving the care, the proportion of nursing assistants  
12 and auxiliary personnel to the registered nurses,  
13 the amount of medical research that goes on in a  
14 hospital will alter the amount of nursing care  
15 required, the administrative procedures in procuring  
16 and maintaining supplies and equipment. All of this  
17 influences the kind of care available for the  
18 patients, so that I think we need a great deal of  
19 study to really be able to plan adequately the nursing  
20 programs that we should have in hospitals and other  
21 health agencies.

22 COMMISSIONER GIRARD: The last recommendation  
23 that I will deal with is Recommendation No. XXIII on  
24 page 39:

25 "That federal government  
26 sponsor a research project in  
27 the administration of hospital  
28 nursing service in order to  
29 determine the factors both  
30 measurable and intangible which







1 result in effective administration".

2 Would anyone care to give more information  
3 on this recommendation?

4 MISS CARPENTER: Miss Campion and the Sister  
5 may wish to speak to this.

6 MISS CAMPION: Well, I think Mr. Chairman and  
7 Miss Girard, if I may speak to this again, that the  
8 quality of administration leadership offered in  
9 hospitals greatly affects the quality of care. There  
10 are certain tangible things which we can measure, some  
11 of which I have measured, which affect the quantity  
12 and quality of care available, and there are certain  
13 intangibles, the relationship of the nursing service  
14 department to the hospital administration, the  
15 relationship of the nursing service department to the  
16 medical staff. If there is, and in many cases there  
17 is an excellent relationship between these groups  
18 working together, then I think that affects the  
19 quality of care, but this is our impression, but you  
20 would want to look at the quality of care given in any  
21 one situation to determine whether these factors really  
22 do in fact influence the quality of care.

23 COMMISSIONER GIRARD: This is what research  
24 would accomplish?

25 MISS CAMPION: I think so.

26 COMMISSIONER GIRARD: Thank you very much Miss  
27 Carpenter and all the others.

28 THE CHAIRMAN: As a matter of fact, purely  
29 the practical aspect of recommendation No. 12, the  
30 education of nurses be under the jurisdiction of





1 institutions whose primary function is education.  
2 Now, we have had a discussion this morning on the  
3 advisability, and we accept if I may say we recognize  
4 what are the views of the nursing profession, as put  
5 forward in this brief on the point, but it is the  
6 practical possibility of seeing this at any time in  
7 the foreseeable future that gives me some concern.

8 How do you see it being accomplished, having  
9 this in mind, that you now graduate 5300 registered  
10 nurses a year from the hospital schools, and 198 from  
11 the university schools, that is from the schools whose  
12 primary function is education. What do you see as to  
13 the possibility of having buildings from which this number  
14 of graduates may be forthcoming each year?

15 MISS CARPENTER: Well sir, I think that we  
16 wish to be realistic, and I think one of the statements  
17 we made in a former submission to the Government was  
18 that we felt nurses should be trained as economically,  
19 as quickly, and as with as high standards as possible,  
20 and if we could see ways whereby we could achieve a  
21 change, we would like to support a change that would  
22 be a sound and a long term basis. We are quite  
23 conscious of the fact that you cannot take a system  
24 that has gone on a hundred years, and within a very  
25 few years change it. You have to work through an  
26 evolutionary process, but at the present time there  
27 is a change to the degree that all of us, as citizens,  
28 are now doing for the education of nurses.

29 THE CHAIRMAN: Yes, through the hospital care  
30 programs?







1                   MISS CARPENTER: Yes, so the money is being  
2   spent now for a type of nursing education. We also have  
3   equipment and supplies and in schools of nursing we  
4   have laboratory areas in hospital schools, and if a  
5   change of administration were possible, if the school  
6   could be a school in the sense of the word, that it  
7   would have control of its students' time, the same as  
8   other schools have, and have its budget, it might be  
9   possible to rent from the hospitals their existing  
10  facilities and to pay, somewhat in the way the  
11  Nightingale School is paying for anything the hospital  
12  provides for the students, and in return get the  
13  cooperation of the hospitals and other health agencies  
14  in the community to assist the school in planning the  
15  essential practice. We don't see that the development  
16  will be sudden, and in fact the recognition of the  
17  facts that we didn't have the answer is a recommendation  
18  in the pilot project that the survey be undertaken,  
19  and in the period when that survey will be complete  
20  and at the present time we are trying to assist these  
21  hospital schools to improve their program to the  
22  degree that they can, but I believe even the  
23  administrators of hospital service commissions are  
24  questioning that the money in the per diem rate of  
25  any patient care should be the method of financing  
26  nursing education.

27                   I read recently a suggestion that perhaps  
28  it is a grant that should be given, but if we get  
29  recognition of the principle for the need for change.  
30  We would not in the Association wish to see any threat





1 to the standard of nursing care we have been able to  
2 achieve in hospitals. The way we would like to see would  
3 be an introduction of a system that would not be, as  
4 we foresee it, all associated with universities. I  
5 think, as we foresee it in our own discussions in the  
6 long distant future we think about 25 per cent of nurses  
7 should graduate from university schools, and about 75  
8 per cent in a diploma program that would be, we hope,  
9 a sound program and give them good education in nursing.  
10 But we wouldn't see the universities taking it over  
11 completely, but we would hope to see something evolve,  
12 and the suggestion that we undertake a study and  
13 waiting for the results of that study is the reason we  
14 feel we haven't got the specific answer to your  
15 question.

16 COMMISSIONER McCUTCHEON: In that connection,  
17 will the bill that has just been brought into the  
18 legislature in Ontario to establish a College of Nurses,  
19 and speaking only from the newspaper reports, will  
20 give the profession control of the standards, reputation,  
21 and licensing and so on. Is that not a first step  
22 to do two of the things that you refer to in here.  
23 First, that you are establishing such standards of  
24 accreditation for hospital schools, and secondly, that  
25 you will have licensure in at least one province?

26 MISS CARPENTER: In Ontario I think there is  
27 at least satisfaction on the part of the Nurses  
28 Association to see this bill go through. It will, as  
29 I understand it, not have to do with accreditation,  
30 which as we understand it is a higher measure, but will







1 have to do with the establishing and raising of minimum  
2 standards, and seeing that the schools reach these  
3 standards and perhaps there will be more control over  
4 the opening and the possible closing of schools  
5 that don't reach standards than there has been in  
6 the past .

7 COMMISSIONER McCUTCHEON: At the same time,  
8 the college, as I understand it, will set the level of  
9 academic achievement?

10 MISS CARPENTER: Yes.

11 COMMISSIONER McCUTCHEON: Set the examinations?

12 MISS CARPENTER: Yes.

13 COMMISSIONER McCUTCHEON: To that extent it  
14 will supersede the R.N. Association? You will have  
15 two divisions, a College which presumably all nurses  
16 will have to belong to, which will deal with matters  
17 of professional standards and conduct and so on, and  
18 you will still have the medical profession and nursing  
19 association, which will deal with the economic aspects?

20 MISS CARPENTER: That is right. It will  
21 have to do with the compulsory licensing of nursing in  
22 the higher levels, including both the registered nurses  
23 and the assistant.

24 THE CHAIRMAN: Would you follow that last  
25 expression up slightly? You are asking the legislature  
26 to have the College also cover those who are nursing  
27 assistants?

28 MISS CARPENTER: As I understand it sir, and I  
29 only have the release from the press too, but I  
30 understand the submission requested that all nurses







1 or higher would be licensed, and this college would have  
2 the licensing responsibility.

3 THE CHAIRMAN: Including the so-called  
4 practical nurses?

5 MISS CARPENTER: The certified nursing  
6 assistant, who is a nurse who has a definite amount of  
7 training already, is a licensed person, or a registered  
8 person I believe it is in Ontario, but the registration  
9 of the certified group has been under the Department  
10 of Health, and the registration of registered nurses has  
11 come under the Association, and now the two groups will have  
12 their licensure regulations under a College of Nurses.

13 THE CHAIRMAN: Is this certified nursing  
14 assistant presently operating under the Department in  
15 the public, or only in the hospital?

16 MISS CARPENTER: Mr. Chairman, she may nurse  
17 in a home if she wishes to, and then she is under the  
18 direction of the doctor who is looking after the  
19 patient.

20 THE CHAIRMAN: So that in a way covers this  
21 word of practical nurse as well?

22 MISS CARPENTER: Yes.

23 COMMISSIONER BALTZAN: In that same regard  
24 Mr. Chairman, following up your question, what is the  
25 distinction between registration and certification?

26 MISS CARPENTER: Is there a difference between  
27 registration and certification?

28 COMMISSIONER BALTZAN: Yes?

29 MISS CARPENTER: These questions, from the  
30 point of view of one province, rather than all the





1 provinces. One thing we have to keep in mind in  
2 relation to the licensure of nursing is that this is  
3 a provincial matter, and so you find that there are  
4 regulations in each province. In the province we  
5 were speaking of, in Ontario, the certification has  
6 been applied to the nursing assistants, and she has  
7 been certified to practice by the Department of Health.  
8 The Division of Nursing of the Department of Health,  
9 and registration has applied to the graduate of these  
10 three or four or five year university programs, and  
11 she has written registration exams, and if she passed  
12 these examinations, been eligible to apply to register,  
13 and she renews her registration each year. Other  
14 provinces have this control of licensing and  
15 registration in a different way, and Ontario never  
16 felt their system was particularly sound, and so this  
17 change is welcomed in Ontario, but someone may wish  
18 to enlighten you in relation to other provinces.

19 COMMISSIONER BALTZAN: My point is that once  
20 a nurse obtains her R.N., then she is regarded as  
21 having completely qualified as a registered nurse, and  
22 still in some provinces she must also apply for  
23 registration, or licensing?

24 MISS CARPENTER: Licensing, yes.

25 COMMISSIONER BALTZAN: Automatically that is  
26 not given to her, because she is a registered nurse  
27 in province X. Province Y would require an additional,  
28 what you call a license?

29 MISS CARPENTER: Yes.

30 COMMISSIONER BALTZAN: Under whose auspices is







1 that?

2 MISS MacLENNAN: Under the provinces that have  
3 licensing, instead of having a Registered Nurses Act,  
4 they have a Practice Act, and under the Practice Act  
5 the qualification is licensing, and under the Practicing  
6 Act nursing and who may call themselves nurses is set  
7 forth in the Practice Act. Under the Registration Acts  
8 we are more limited in what the Association does have  
9 control of in the life of a nurse, more with  
10 educational and schools, rather than the total field  
11 of nursing and who nurses, so that the desirable aim  
12 of the profession is to obtain Practice Acts which  
13 will clarify the area of nursing, and we would not  
14 have this problem of what are medical activities and  
15 what are nursing activities confusing us so, but only  
16 four provinces as yet have achieved a Practice Act  
17 for nurses, and those that have the Practice Act, then  
18 the permit to practice is called a license. Where  
19 we just have the Registration Act, then the permit  
20 to practice is registration.

21 THE CHAIRMAN: So we will have to obtain this  
22 information through our research staff, the legislative  
23 positions of the various provinces?

24 MISS MacLENNAN: Yes.

25 THE CHAIRMAN: In dealing with the number of  
26 nurses available, because of the suggestion that while  
27 we are favourably situated in Canada we could do with  
28 more. On page II in the summary and recommendations  
29 you say:

30 "There is at present





1 approximately one registered  
2 graduate nurse in Canada for  
3 every 260 people."

4 Is that the working force or the potential?

5 MISS CARPENTER: That is the potential sir.

6 The work force I think is 380 some. It is in another --

7 MISS CAMPION: 345.

8 MISS CARPENTER: That is the potential.  
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1 THE CHAIRMAN: And still dealing with  
2 the work force, you say on page 6 of the same summary:

3 "With further reference to the availa-  
4 bility of nursing skills in Canada,  
5 the Canadian Nurses' Association  
6 suggests that vigilance be exercised  
7 to make certain that no deterrents  
8 are placed in the way of married  
9 registered nurses ----"

10 Are there any deterrents now which you  
11 wish to draw to the attention of the Commission?

12 MISS STIVER: Mr. Chairman, I believe  
13 there have been deterrents to married women nursing;  
14 certain agencies and hospitals, not probably hospitals  
15 now because I believe hospitals now are almost half-  
16 staffed with married nurses but I have known public  
17 health agencies where it was not possible to hire  
18 married nurses or, if so, they were not fully utilized.

19 I mean, married nurses who are able to  
20 go half-time, it was difficult, it was impossible to  
21 arrange the program so that those nurses could be hired;  
22 they either had to be there during the full day or not  
23 at all.

24 Yet, there were experienced nurses  
25 who could have made a contribution on a part-time basis  
26 but it was not possible to hire them.

27 THE CHAIRMAN: Those things are amongst  
28 the matters which you refer to here as deterrents?

29 COMMISSIONER McCUTCHEON: I have an  
30 impression and maybe you can correct me if it is wrong,







1 that some substantial groups of employers of nurses  
2 differentiate for pension purposes between single nurses  
3 and married nurses; is that correct?

4 MISS MacLENNAN: I know of some agencies  
5 where a nurse who has been a supervisor marries and she  
6 then loses her pension privileges, she becomes a tempo-  
7 rary instead of a permanent employee as far as the  
8 employment and fringe benefits apply.

9 THE CHAIRMAN: You may have covered in  
10 the brief and I may have missed it on this section but  
11 if you have some definite information on this point  
12 would you make that available to us?

13 MISS CARPENTER: Yes, sir.

14 COMMISSIONER VAN WART: Referring to  
15 Recommendation IV on page 9, I wish to ask a series of  
16 questions. It has been recommended to the Commission  
17 that psychiatric patients be treated in the wards of a  
18 general hospital or in psychiatric wings of a general  
19 hospital; is your Registered Nurses' Association in favour  
20 of this trend?

21 MISS CARPENTER: Mr. Chairman, I would  
22 think our Association is in favour of any trend that  
23 will improve the care of psychiatric patients. Many of  
24 us do feel, of course, that these patients would be  
25 well cared for in the general hospital in psychiatric  
26 wards, would not have the separation from their family  
27 and friends that they have sometimes in psychiatric  
28 hospitals.

29 Also, sometimes they have an unfortunate  
30 connotation that is placed on their illness when they





1 are placed in a separate institution. If the movement  
2 is this way I think we would be very interested in it  
3 and would hope that the nursing profession could keep  
4 pace with offering a quality of care in these units or  
5 wards in general hospitals that is required.

6 COMMISSIONER VAN WART: At the present  
7 time have you the nursing personnel to look after these  
8 patients?

9 MISS CARPENTER: Well, I think that we  
10 find in many situations in Canada that we are able to  
11 staff units now in operation. We do find, of course, a  
12 delay in being able to staff new facilities that open up.

13 Now, in reference to the staffing of  
14 facilities now in operation we are not always happy with  
15 the standard of staffing or the quality of the staff but  
16 certainly I think in the current situation, with the empha-  
17 sis on in-patient hospital care, it is difficult to find  
18 a staff for new units that open and if they open quickly,  
19 as they do in some cases, there is a delay between the  
20 time those facilities are available and they can be put  
21 to use.

22 COMMISSIONER VAN WART: Do you, as a  
23 Registered Nurses' Association, visualize anything against  
24 this movement that is being mooted, coming into effect?

25 MISS CARPENTER: I personally cannot see  
26 anything against it; I do not know whether any of the  
27 group here would comment on that.

28 COMMISSIONER VAN WART: Would you use  
29 those units for teaching purposes for psychiatric nurses?

30 MISS CARPENTER: Yes, we also use them







1 in many situations in which I am familiar for teaching  
2 purposes.

3 COMMISSIONER VAN WART: Turning to  
4 page 17 you state that the interest of the nursing  
5 profession has increased in the psychiatric patients  
6 since:

7 "The changing emphasis to therapeutic  
8 rather than custodial care, the  
9 improved working conditions and  
10 personnel policy, provides for more  
11 satisfaction in psychiatric nursing."

12 Now, in the mental institutions do the  
13 registered nurses do any of the nursing administration?

14 MISS CARPENTER: Yes, as a registered  
15 nurse in the mental institutions may be directors of  
16 nursing or head nurses, in this way they are undertaking  
17 administration, yes.

18 COMMISSIONER VAN WART: And in the  
19 lower levels, floor supervision and so on?

20 MISS CARPENTER: I would think so. I  
21 would think that would be distributed. I do not know  
22 whether anybody here ---

23 MISS CAMPION: I understand there is  
24 quite a wide variation in this but in many of the psychia-  
25 tric hospitals a registered nurse is in both administra-  
26 tion and teaching.

27 COMMISSIONER VAN WART: Is it an isolated  
28 practice or general?

29 MISS CAMPION: I would not say it was  
30 isolated or general, there is a variation in the number





1 of registered nurses who are in the administrative  
2 position.

3 MISS CARPENTER: If I may add to that,  
4 in a province such as Ontario where the nurse is trained  
5 in a psychiatric hospital, has also general training  
6 and is a registered nurse, of course, those nurses are  
7 registered nurses and they, to a degree, remain in  
8 employment at these hospitals although they do move  
9 around.

10 It is really only in the western  
11 provinces where you have this difference and if someone  
12 is a psychiatric nurse only undertaking administration -  
13 I do not know if that is what you are referring to. I  
14 think, going from Manitoba and going east where there  
15 are registered nurses in psychiatric hospitals they are  
16 undertaking all categories of nursing care that registered  
17 nurses are qualified to undertake.

18 COMMISSIONER VAN WART: Has your organiza-  
19 tion any responsibility in the training of psychiatric  
20 nurses?

21 MISS CARPENTER: Well, the training of  
22 nurses is a responsibility at the provincial level and  
23 we, as a national Association, can only make recommenda-  
24 tions of a general nature. We suggest that provincial  
25 associations and provincial bodies deal with these  
26 problems.

27 We have participated in studies in the  
28 preparation of psychiatric nurses and have tried to  
29 assist in local situations as we can working on employment  
30 with local nurses to develop methods of preparing nurses





1 to enter this field.

2 COMMISSIONER VAN WART: Have you  
3 submitted specific recommendations for the training of  
4 psychiatric nurses?

5 MISS STIVER: No, I do not think we  
6 have. I think we find there is confusion sometimes  
7 with this term "psychiatric nurse". This term means  
8 one thing in the western provinces and something else in  
9 the eastern provinces; in the western provinces it means  
10 a person who has taken their three years in a psychiatric  
11 hospital only and has graduated as a psychiatric nurse.

12 In the eastern provinces, Ontario and  
13 east, the term "psychiatric nurse" means a registered  
14 nurse who also has preparation for psychiatric nursing.

15 There are registered nurses in the  
16 eastern part of Canada who would say they are psychiatric  
17 nurses because they are registered nurses with additional  
18 preparation in psychiatric nursing. It can mean two  
19 things.

20 COMMISSIONER VAN WART: The chief  
21 hindrance for a psychiatric nurse to become a registered  
22 nurse is the preliminary educational standard which a  
23 registered nurse requires; is that not true?

24 MISS STIVER: That is one.

25 COMMISSIONER VAN WART: I believe in  
26 western Canada the psychiatric nurse, when they enter  
27 general hospitals, are treated as orderlies and the  
28 other analogy is the nursing assistants are treated as  
29 nursing assistants because they have not the preliminary  
30 education. I think that is a factor that differentiates







1 them from registered nurses; am I correct?

2 MISS CARPENTER: Well, the other factor  
3 is in the content of their preparation which is limited  
4 to one area. This is a trend throughout the world and  
5 countries that have had this problem are trying to over-  
6 come it now and trying to help to equip a nurse for  
7 nursing care in any situation.

8 Dealing with the staff situation is not  
9 the important thing but the principles of nursing should  
10 be applicable to any situation and the individual who is  
11 doing the nursing should be able to apply this to any  
12 situation.

13 We, in our Association, support the  
14 concept of preparing a nurse to ply her nursing knowledge  
15 in any situation and we do support the development of  
16 having the nurse receive some of her content and some of  
17 her experience in psychiatric nursing and in a psychiatric  
18 wing.

19 COMMISSIONER VAN WART: You have no  
20 program, as a Registered Nurses' Association, to train  
21 psychiatric nurse administrators?

22 MISS CARPENTER: Well, universities  
23 have programs of this kind and any universities where  
24 they assist the graduate nurse on any course to enter  
25 and take preparation in administration and supervision,  
26 one area in which they may specialize in these courses  
27 is in psychiatric nursing.

28 COMMISSIONER VAN WART: I believe your  
29 Association recommends increased number of male nurses  
30 to be trained; could you visualize many of these nurses





1 may enter the field of psychiatric nursing?

2 MISS CARPENTER: Well, the fact that  
3 many of them have entered psychiatric nursing has some-  
4 times been - they have been encouraged but it was  
5 through the financial remunerations given to the students  
6 in these hospitals.

7 I think there has been an active effort  
8 to recruit in psychiatric hospitals because they have had  
9 the most extreme shortage of nursing services and in  
10 some instances they have recruited men.

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1                   MISS CARPENTER: We feel that if men would  
2 enter nursing we, as an association, would welcome the  
3 inclusion of men amongst the ranks of nurses. We do  
4 not think that it is necessarily limited to  
5 psychiatric nursing. It might be any kind of nursing  
6 but I think the whole area of motivating men to enter  
7 nursing is related to our culture and economy and we  
8 do not foresee in the near future that a large number  
9 of men will enter any field of nursing, let alone  
10 psychiatric nursing.

11                   COMMISSIONER VAN WART: Leaving that field,  
12 and coming to another field I notice there is no  
13 mention in your brief at all regarding the training of  
14 midwives. Is your Association in favour of the  
15 training of midwives such as they have in some of the  
16 Western provinces?

17                   MISS CARPENTER: Well sir this has not come  
18 up for discussion actually. You are touching on an  
19 area where I think the nursing profession accepts  
20 that obstetrical practice is, in this country, a  
21 medical practice.

22                   Now it is true that this is another area  
23 we could have discussed earlier this morning in relation  
24 to areas in which nurses sometimes take over  
25 responsibilities for which they have not been prepared,  
26 and in rural areas in the northern part of our  
27 country we do find that nurses are undertaking the  
28 care of patients during labour and delivery when they  
29 have not sufficient qualifications for this and the  
30 Alberta government recognizing this has done something





1 to give nurses what we call an advance obstetrical  
2 training so that they can be safer in relation to  
3 that when they are under these circumstances.

4 Of course, with the emergence of airplane  
5 travel, and so on, we find that even in the northern  
6 country many of these patients are now being moved  
7 to hospitals in time to have the obstetrician assist  
8 the mother at the time of delivery.

9 Whether in this country we should do more  
10 to prepare nurses in this field I think again is an  
11 area where the medical profession and the nursing  
12 profession might well think this thing through together  
13 and try to find to what extent nurses should take on  
14 more senior preparation.

15 COMMISSIONER VAN WART: Is your Association  
16 in favour of expansion of this existing service?

17 MISS CARPENTER: I think sir again the  
18 question, when Miss Campion answered the question  
19 earlier this morning in relation to these areas, would  
20 apply here. If we keep on increasing the amount of  
21 education preparation, the number of services that  
22 nurses are asked to undertake, we take them away from  
23 what has been traditionally known as nursing care.

24 I know that when nurses are in a position  
25 where they have to care for a mother during delivery  
26 feel a great responsibility and feel that their  
27 preparation is not sufficient to be giving the mother  
28 the assurance of safety that she must have at this  
29 important time and it is quite an undertaking to  
30 suggest at this point that we recognize the weakness







1 of education now, that we should -- recognize the  
2 demands on nurses that we should now take on  
3 another field. I think we would want this held in  
4 abeyance until we get some of the current problems  
5 settled.

6 COMMISSIONER VAN WART: Then you are not in  
7 favour of the expansion of this program?

8 MISS CARPENTER: I think that is true at the  
9 present time. Although if the medical profession say  
10 we cannot staff the northern countries and nurses are  
11 needed to staff the northern country, that we are also  
12 not in favour of unsafe obstetrical practice for  
13 people who live in the north.

14 COMMISSIONER VAN WART: This does not necessarily  
15 mean unsafe obstetrical practice.

16 THE CHAIRMAN: That is not what Miss Carpenter  
17 means. She means it was unsafe to leave them even  
18 without nurses.

19 MISS CARPENTER: Even without nurses or with  
20 nurses who do not have sufficient knowledge to assist  
21 the mother.

22 COMMISSIONER VAN WART: You can realize this  
23 is an important thing in the field of health in which  
24 we would have to make a decision. We would like to  
25 have your opinion. In your opinion, as I judge it,  
26 you are not in favour of this service?

27 MISS CARPENTER: I think that is true.

28 MISS MacLENNAN: If I might state historically,  
29 that the Canadian Nurses' Association in the 'forties  
30 made a special request to the Canadian Medical







1 Association with respect to the field of midwifery,  
2 whether or not the medical profession would retire  
3 from that field and let nursing enter the field of  
4 midwifery, and I think you will find on the books of the  
5 Canadian Medical Association at one of those annual  
6 meetings, they did not approve of nurses moving into  
7 the field of midwifery, so for the Canadian Nurses'  
8 Association felt they were not in position, the  
9 Medical Practices Act being set up as it is -- they hold  
10 the field of obstetrics in what we would term midwifery,  
11 so that there is nothing that the nurses can take over  
12 in the Medical Practice field as long as the  
13 Medical Practice feel that item is in their scope of  
14 work.

15 I know the Womens' Institute and the I.O.D.E.  
16 were asked actually if they wanted to push this -- the  
17 Womens' Institute in particular being concerned with  
18 rural women -- that they might have some effect on the  
19 Canadian Medical Association's point of view and the  
20 Canadian Nurses' Association at that time was perfectly  
21 willing to proceed with the training of midwifery if  
22 we were legally allowed to enter the field but the  
23 Canadian Medical Association's answer at that time was  
24 no.

25 COMMISSIONER VAN WART: Your Association is  
26 not in favour of it?

27 MISS MacLENNAN: Your Association.

28 COMMISSIONER VAN WART: I am asking about yours.

29 MISS MacLENNAN: We were in favour of nursing  
30 moving into the midwifery field at that time.





1 MISS CARPENTER: Miss Campion I think you have  
2 a point?

3 MISS MacLENNAN: We have not discussed it  
4 since. There has been no change, as far as we know,  
5 in the Canadian Medical Association's point of view.

6 MR. HENDERSON: It seems to me that the  
7 burden of this submission is one cannot answer that  
8 in black and white, yes or no. The submission is that  
9 if there is a need to be filled, and this Association  
10 says that nurses should fill that need, this submission  
11 is: education should be such that that need is properly  
12 filled for the safety of the patient and for the overall  
13 health service system generally.

14 I do not think it is intended to say that  
15 regardless of the need, the Association is against it.  
16 The submission is that if the need is to be filled and  
17 this Association then is properly to fill it, education  
18 should be such that that need is properly filled. The  
19 two are not unrelated.

20 THE CHAIRMAN: You were going to add something  
21 Miss Campion?

22 MISS CAMPION: I think Mr. Henderson has  
23 covered the point I was going to make.

24 THE CHAIRMAN: Now I do not think we can  
25 finish this this morning but if it is convenient for  
26 you to come back at 2:00 o'clock, I think we can be  
27 through by half past two.

28 MR. HENDERSON: May I be excused?

29 THE CHAIRMAN: Yes. Is that satisfactory?  
30 We will rise until 2:00 o'clock.  
---Luncheon adjournment.







1 ---On resuming at 2:00 p.m.

2 THE CHAIRMAN: Mr. Baltzan, you had some  
3 questions.

4 COMMISSIONER BALTZAN: Would you please tell  
5 me if I am correct that somewhere in your brief, your  
6 theme, your motif, the keystone to the whole  
7 professional conduct and behavior is based on the fact  
8 of your experiences gained, learned, and you began to  
9 feel at the bedside? This brings up the question of  
10 learning versus experience. There is so much talk  
11 about dictation, so much talk about experience,  
12 clinical teaching. Is this a continuing motif in the  
13 nursing profession?

14 MISS CARPENTER: Yes, Mr. Chairman, Dr.  
15 Baltzan, I think that we, in any change in nursing  
16 education, see the need for nurses to have an  
17 opportunity for clinical experience. I think the  
18 reason why we wish to see a change is that so much  
19 of the nursing experience that the nurse gets in her  
20 education is unsupervised experience, and one hopes  
21 in any change one will find theory and practice  
22 related and that the teachers teaching the theory  
23 also being with the nurse to help her in practice and  
24 the learning would be related to the classroom. But  
25 there would be a good time of the students spent in  
26 the clinical, both in the hospital and outside in the  
27 other health fields where patients are cared for.

28 COMMISSIONER BALTZAN: Yes, I think that  
29 answers the question. Would you please also tell me,  
30 to get my own thinking correct, that you are now





1 embarked on three forms of schools: one is the  
2 traditional hospital school for the training of nurses,  
3 and the intention is to, with modifications, so continue  
4 in that basis, support that kind of training as it goes  
5 with a school of nursing attached to or with a hospital?

6 MISS CARPENTER: Well, sir, I think it depends  
7 on whether we can understand each other in words. I  
8 think the hospital school as it now exists, we would  
9 hope in the long term view would no longer exist in the  
10 sense that the hospital school so far hasn't been able  
11 to provide for the school to have complete control of  
12 the student time, and whether a hospital can ever make  
13 this provision we question, because, after all, the  
14 hospital's primary purpose is service, and when a  
15 situation develops where there isn't sufficient service  
16 and there are students of the hospital, then those  
17 students are used for service. So we would hope that  
18 the modification, in whatever form of education, would  
19 overcome this problem. We wouldn't like to say what  
20 form that change would take, but we do recognize as  
21 an association that whatever change occurs won't  
22 occur quickly, that it has to occur gradually.

23 COMMISSIONER BALTZAN: But you say whatever  
24 recommendations you have, that can be perpetuated; you  
25 are not seeing in the near future entirely a break  
26 from the old traditional, not exactly planned, a new  
27 curriculum, a new form in your directors and  
28 supervisors, that that kind of combination might be  
29 counted on to prevail, or have you reached a crossroads?

30 MISS CARPENTER: I would say that we wait







1 before we say positively, because we are, after all,  
2 spending thousands of dollars a year to get this study  
3 launched and we wish this study made as to the best  
4 organization there should be to get the best schools  
5 of nursing in the country. I think many of the persons  
6 concerned with the administration of hospital  
7 commissions cannot foresee that the education of  
8 nurses belongs to the hospital; they should be  
9 partners in the venture, but the primary responsibility  
10 is an educational one and not an institutional one.

11 COMMISSIONER BALTZAN: A good many of the  
12 nurses only do, say, forty hours a week, out of which  
13 is experience.

14 MISS CARPENTER: Even with the number of  
15 hours the student is obliged to serve the hospital has  
16 reduced, and we recognize that some of those hours  
17 are for experience, nevertheless, one shouldn't start  
18 planning around the service; it will be around the  
19 training and practice that the student needs and the  
20 conditions under which that planning should be  
21 developed.

22 COMMISSIONER BALTZAN: Not too far in the  
23 past is the advent of the university college degree  
24 versus the diploma, and you are not graduating any  
25 more than about 200 a year. The ultimate in  
26 nursing, recognizing the value of this, is not  
27 necessarily centred on this ultimate, that the nurses  
28 will eventually be also baccalaureate people.

29 MISS CARPENTER: Well, I believe I can  
30 answer that by saying we hope eventually that 25 per







1 cent of employed nurses would come into nursing through  
2 the university program, some of these nurses, and we  
3 hope a fair proportion would be giving nursing care  
4 and, our hope, helping the diploma type nurse to  
5 improve the care, having someone with academic  
6 qualifications and intellectual ability helping the  
7 bedside and in the ward. Also from that school of  
8 university graduates could come people who could  
9 teach and who could have administrative abilities  
10 and perhaps people who could be engaged in research.

11 One area in which we are concerned  
12 about quality of nursing care is that there is really  
13 almost no research into how to give the quality of  
14 care, what factors make a patient recover more quickly.

15 THE CHAIRMAN: I am just suggesting  
16 that we covered all this this morning.

17 COMMISSIONER BALTZAN: True, but I am  
18 just trying to get the thing organized in my mind,  
19 because I am coming to questions on something with  
20 which I am not too thoroughly acquainted, and I want  
21 to know which way we are heading in regard to the  
22 new departure in relation to separate colleges?





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MISS CARPENTER: Are you speaking of the universities?

COMMISSIONER BALTZAN: No, I am speaking of some things I have learned about in the United States, and I think also this Nightingale School, in Toronto.

MISS CARPENTER: In the United States, Mr. Chairman, if I may answer that, there has been a development of nursing education in what they have as junior colleges, which are colleges like the universities that are giving two years of post-high school education.

In Toronto, the Nightingale School is a school that is continuing, really, in a sense, in an experimental way. The Ontario Hospital Services Commission and the Federal Government have contributed funds to establish a school on a separate budget, and complete control of students' time, and it is located on the grounds of the New Mount Sinai Hospital, and the hospital co-operates with the school in providing opportunities for the practice the students need, and practice is also secured in other hospitals and health agencies in the community.

This is experimental in the sense that here is a new approach to budgeting. The principles of the curriculum and the planning of the course are







1 principles that were experimented with in the Metropolitan  
2 school in Windsor, which we speak of in this report.

3 COMMISSIONER BALTZAN: From the learning  
4 standpoint, is there any severe departure from what we  
5 have known in regard to the program?

6 MISS CARPENTER: I think the departure  
7 is that the staff of the school decide the kind and the  
8 amount of practical experience the students will have,  
9 and the Mount Sinai Hospital make it possible for the  
10 students to have that amount, but it is the faculty of  
11 the school which completely controls students' time, and  
12 they say where the students should be, in the classroom,  
13 in the library, or in the hospital, where they should be.

14 COMMISSIONER BALTZAN: In the wards, do  
15 they have a certain feeling of independence, or is it  
16 under supervision?

17 MISS CARPENTER: It is under the super-  
18 vision of the staff who teach the nursing, the New Mount  
19 Sinai Hospital have graduate staff, who are the staff of  
20 the hospital, and the head nurse is the head nurse of the  
21 hospital work, and the staff make it possible to relin-  
22 quish certain patients to the school, and to the students,  
23 and at the time the students are gaining their practice  
24 an instructor from the school is with the students, and  
25 is responsible to the head nurse for the quality of care  
26 the patients receive from the students, but the hospital  
27 staff do not undertake supervision of the students  
28 during the practice.

29 COMMISSIONER BALTZAN: From your long  
30 experience, Miss Carpenter, do you feel that the practical





1 experience gives a nurse at the end of her three years,  
2 or whatever it is, something as good as formerly?

3 MISS CARPENTER: Mr. Chairman, this  
4 school now is in its second year. The first group will  
5 graduate in the summer of this year. In the Windsor  
6 experiment we found the students were as good, or better,  
7 than the three-year people, and they were prepared in  
8 two years.

9 I have every confidence that they will  
10 be better than the students in the average three-year  
11 hospital school.

12 COMMISSIONER BALTZAN: I could carry  
13 this on further, but I think you have straightened up  
14 the three main questions I wanted. I don't know what  
15 page, but it is paragraph 70, where you point out that  
16 you are the only people I have heard of with de-automa-  
17 tion:

18 "Automation has reduced the number of  
19 people needed in many industries, even  
20 when the output of those industries  
21 has grown. In nursing the case is  
22 reversed - one might say doubly  
23 reversed."

24 MISS CARPENTER: I know, Mr. Chairman,  
25 and Dr. Baltzan, we discussed this a good deal. Miss  
26 Campion, I think, would be prepared to speak to it.

27 MISS CAMPION: Mr. Chairman, Dr. Baltzan,  
28 to me I think it is clear that in industry automation  
29 has been introduced which has reduced the number of people  
30 in carrying out, preparing the product, whatever it may







1 be, whereas in nursing we cannot say the same thing.

2 Now, in the overall hospital administra-  
3 tion, a great deal of automation might be introduced in  
4 the way of preparing and delivering supplies. It would  
5 provide for a much more efficient operation of the hospi-  
6 tal, but in the actual nursing care of the patient there  
7 have been no automative devices whereby you could put  
8 the patient on an assembly line and push buttons.

9 COMMISSIONER BALTZAN: Thank you. It  
10 is very clear in here, and the only reason I referred to  
11 it was because it is so refreshing.

12 COMMISSIONER STRACHAN: Mr. Chairman,  
13 with reference to the fact that 84% of the schools of  
14 nursing would fail at the present time to qualify for  
15 accreditation, I think it is reasonable to presume that  
16 these are mostly connected with hospitals, and those  
17 hospitals, the majority of them, have qualified for  
18 hospital accreditation.

19 They have also qualified so far as the  
20 Royal College of Physicians and Surgeons is concerned.  
21 It would seem to me that there must be a narrow line  
22 dividing here somewhere. Where have these schools of  
23 nursing in connection with hospitals been led?

24 MISS CARPENTER: Well, Mr. Chairman,  
25 I think there is a difference between accrediting a  
26 hospital in relation to service, and one in accrediting  
27 in relation to education.

28 The criteria used were criteria that we  
29 feel are commonly accepted in any educational setting,  
30 and the school has an administration, a budget, a library,







1 and students have access to the library and so on.

2 There is a curriculum, in which theory  
3 and practice are related, and so on, and it was these  
4 criteria that were used, and it was considered, 25  
5 schools selected as an unbiased sample, and they were  
6 all hospital schools, and of the 25 selected four met  
7 these criteria, and the rest didn't.

8 COMMISSIONER STRACHAN: You mention  
9 poor design and layout of hospitals. Are hospitals  
10 still being constructed with poor design and layout?

11 MISS CAMPION: I think a great deal  
12 could be done to improve the design and layout of  
13 hospitals in line with what the hospitals are attempting  
14 to do.

15 There is a change in patient care,  
16 insofar as patients up and around, and we need more in  
17 the way of day rooms for patients. In many hospitals,  
18 very recent ones too, for instance, the rooms for medica-  
19 tion are very small. There has been such a great  
20 increase in the number of medications which have to be  
21 prepared and given to patients, and you need a good-sized  
22 medication room if three, or four, or even five nurses  
23 wish to prepare medications at one time, and the rooms  
24 are quite inadequate.

25 COMMISSIONER STRACHAN: If this is a  
26 generally recognized fact, it seems very odd that they  
27 should continue making these mistakes, or are they not  
28 recognized by the proper authorities?

29 MISS CAMPION: As we pointed out, we  
30 feel that nurses might contribute more to the planning





1 of hospitals, because they are the ones working in the  
2 hospitals, and many of the new hospitals have greatly  
3 improved, but of course all hospitals are not new  
4 hospitals.

5 COMMISSIONER STRACHAN: Referring to the  
6 deterrent to married personnel in respect of nursing, is  
7 the income tax also a deterrent, as has been mentioned  
8 by other bodies?

9 MISS CARPENTER: Well, Mr. Chairman, I  
10 think whatever deterrent income tax deductions are for  
11 married women in nursing, it is the same in any other  
12 occupation.

13 I do think there is a tendency on the  
14 part of married women and their husbands to not like  
15 the idea of having their income tax level change when  
16 the wife earns up to a certain amount. I think many  
17 nurses and teachers go ahead and work, despite this.

18 I think that in the services where they  
19 are very much in demand that the couples, both man and  
20 wife, see the need for the woman to contribute as she  
21 can. Whether anything should be done to change this I  
22 think we, as an Association, have mixed opinions in this  
23 regard.

24 THE CHAIRMAN: Before I ask Dr. Firestone  
25 to deliver whatever questions he may have, you might  
26 permit this observation, that accepting that you must  
27 tie your ambitions to a star, can you tell us if there  
28 is any other country in the world with all these deficien-  
29 cies you are talking about that have a higher qualified  
30 registered nurse than we have in Canada?







1 MISS CARPENTER: I think the answer  
2 would be to ask these countries. I think many countries  
3 think they have better nurses than we.

4 THE CHAIRMAN: Are there any countries  
5 where the Canadian nurse is not welcomed with open arms?

6 MISS CARPENTER: Yes, there are.

7 THE CHAIRMAN: Only with qualifications  
8 I mean.

9 MISS CARPENTER: There are countries  
10 where nurses cannot get registered from Canada, and they  
11 have to wait for registration, and it is because the  
12 criteria in certain countries are different to our own.

13 THE CHAIRMAN: Can you suggest one?

14 MISS CARPENTER: Well, New York State  
15 sometimes keeps a nurse from registering. England some-  
16 times.

17 THE CHAIRMAN: Did you see a newspaper  
18 advertisement where they were up from New York, wanting  
19 to get all the nurses?

20 MISS CARPENTER: Yes, but when the  
21 Canadian nurses go to register there, some from certain  
22 schools have difficulty, for instance, if they do not  
23 have a psychiatric training.

24 COMMISSIONER VAN WART: Do they not  
25 have to take out their first papers?

26 MISS CARPENTER: I think they do and  
27 in certain states citizenship.

28 COMMISSIONER FIRESTONE: This is a very  
29 fine brief. I have a few questions which concern mainly  
30 an elaboration of what you and your colleagues have to





1 say, and therefore if you feel it might be easier to  
2 consider these questions and let us have your considered  
3 opinion in writing at a subsequent date, it would be  
4 quite all right.

5 MISS CARPENTER: Thank you.

6 COMMISSIONER FIRESTONE: My first  
7 question relates to the third paragraph on page II,  
8 under Summary and Recommendations, and I am quoting the  
9 last sentence:

10 "Canada does suffer from a seeming  
11 shortage of nurses"

12 and you elaborate that point subsequently on page 16,  
13 in paragraph 57, and you say that there is a shortage  
14 of nursing services in Canada both in quality and quantity.

15 Would you tell the Commission on what  
16 you base the observation there is a seeming shortage of  
17 nurses in Canada?

18 MISS CARPENTER: Well, I think sir, if  
19 I may answer that, it is in the number of positions that  
20 it is difficult to fill. This is one area in which the  
21 shortage occurs. It is in the reliance we have to place  
22 on recruitment from other countries, sometimes into this  
23 country.

24 This is the sort of thing. Actually  
25 the shortage, although we speak of it in the staff level  
26 positions more frequently I think it is most severe and  
27 critical in the senior level positions.

28 COMMISSIONER FIRESTONE: So therefore,  
29 when you speak of, and I quote: "seeming shortage", you  
30 really refer to an actual shortage, is that correct?







1 MISS STIVER: Mr. Chairman, if I might reply  
2 to Professor Firestone. I think the thought there is  
3 that we are not certain whether it is a shortage of  
4 nurses or a shortage of nursing. Perhaps if we were  
5 able to use all the nurses we have for nursing only  
6 then we might not have a shortage. We do not know.

7 COMMISSIONER FIRESTONE: But given the  
8 present use and utilization of nurses is there a  
9 shortage of nurses in Canada or is there not?

10 MISS STIVER: We would believe that in  
11 certain areas there is a shortage.

12 COMMISSIONER FIRESTONE: If there are a  
13 shortage of nurses in certain areas then the country as  
14 a whole is short of nurses, it is an actual shortage  
15 rather than a "seeming shortage"; is that correct?

16 MISS STIVER: There are two problems here, one  
17 is distribution and the other is utilization.

18 MISS CARPENTER: I think I might add, if  
19 as a result of this Commission hearing there is a change  
20 in the prepayment arrangements for health services and  
21 we have out-patient departments prepaid and home care  
22 prepaid and we are bringing the family more into the  
23 picture, again it may be with the numbers we are  
24 producing we can handle the demands but with the  
25 current of methods of in-patient hospital care I think  
26 there is a shortage.

27 COMMISSIONER FIRESTONE: There is an actual  
28 shortage rather than a "seeming shortage"?

29 MISS CARPENTER: Yes.

30 COMMISSIONER FIRESTONE: Would it be possible







1 for you to give some consideration and tell the  
2 Commission what in your opinion is this shortage in  
3 terms of numbers of nurses required to bring it up to  
4 what you would consider a desirable standard given the  
5 present utilization of nurses. I would not want you  
6 to answer this question quickly or lightly but if you  
7 could give some consideration to this matter and  
8 advise us it would help us in our deliberations.

9 When you make those comments will you please  
10 bear in mind the point raised a little earlier, that  
11 is, the uneven distribution because, if I understand  
12 the point of uneven distribution correctly, it would  
13 mean that you may have surpluses of nurses in one  
14 area and shortages in another. I am not aware of  
15 any nursing association having suggested in any of  
16 the provinces in which we have been that there are  
17 any surpluses of nurses anywhere given the present  
18 utilization.

19 Now, could you, therefore, bear in mind not  
20 only quantities but distribution and quality which you  
21 refer to in paragraph 57.

22 Now, in this connection could you also have  
23 some comment as to whether you feel there is such a  
24 thing as an appropriate national ratio between  
25 registered nurses and auxiliary nursing personnel as  
26 you have presented on Table II on page 42 in appendix 2.  
27 You have shown that the ratio is 1.5 per cent in Canada  
28 and this compares with 6.6 per cent in the United  
29 Kingdom and 3 per cent in Australia and 1.2 in the  
30 United States. I am just wondering whether these ratios





1 are really meaningful and if they are not meaningful  
2 what is their purpose? You understand, in trying to  
3 formulate the nursing program for another twenty years  
4 or so you want to see the proper place between the  
5 auxiliary nursing personnel to the registered nurses.  
6 We would appreciate some guidance, quantity or otherwise  
7 as to what such a plan should entail: should we have  
8 more auxiliaries in relation to registered nurses or  
9 fewer and whatever your recommendation is, why.

10 Could I turn now to page IX; in your  
11 recommendation II you recommend the establishment of  
12 an advisory committee on health services on regional and  
13 national levels. Could you give some further  
14 consideration to what the functions and specific terms  
15 of reference of an advisory committee on health services  
16 at a national level should entail with nurses participating.  
17 We are looking again for specific advice and recommendations  
18 from you which will help us in our deliberations.

19 The next point relates to page XI,  
20 recommendation No. X; you speak here about preparing  
21 extra nurses in training and then you conclude with:

22 "That having acquired advance  
23 preparation they be accorded recognition,  
24 authority and remuneration in line with  
25 their responsibility."

26 Now, what I would like to know from you is how  
27 can this be achieved? How can, particularly the  
28 federal government, what can the federal government do  
29 to encourage hospitals which are largely under provincial  
30 jurisdictions to "accord recognition, authority and







1 remuneration in line with their responsibility"? As  
2 you know this is a Royal Commission advising the  
3 federal government, what can the federal government do  
4 to achieve this?

5 MISS CARPENTER: Well, one thing comes to my  
6 mind, we think the federal government hospitals could  
7 set a leadership pattern in this regard.

8 COMMISSIONER FIRESTONE: That is what you are  
9 recommending?

10 MISS CARPENTER: Yes, I would think so and I  
11 guess, perhaps, in other ways they could advise in that  
12 they do have committees on the administration and  
13 development of hospitals under hospital insurance plans.  
14 I expect they could advise the provincial bodies. The  
15 organization is not at the federal level in relation to  
16 hospitals that are municipal and provincial, of course.

17 COMMISSIONER FIRESTONE: In other words, you  
18 would hope once the federal government sets the pattern  
19 which your Association considers appropriate it would  
20 be left for others to follow the lead and if they did  
21 not you could point to this example to help you in your  
22 own negotiations at the provincial or municipal level?

23 MISS CARPENTER: Yes, sir.

24 COMMISSIONER FIRESTONE: If we might now turn  
25 to page XII, recommendation 14, you recommend here:

26 "That financial aid be made  
27 available to all students who need  
28 assistance both prior to and during  
29 the basic nursing education program."  
30 Do you have in mind here bursaries and

The first part of the paper discusses the importance of maintaining accurate records of all transactions. It is essential for the business to have a clear and concise record of all income and expenses. This will allow the business to track its financial performance over time and identify areas where it may be able to reduce costs or increase revenue.

The second part of the paper discusses the importance of maintaining accurate records of all assets and liabilities. This will allow the business to track its net worth over time and identify areas where it may be able to increase its assets or reduce its liabilities.

The third part of the paper discusses the importance of maintaining accurate records of all taxes paid. This will allow the business to track its tax liability over time and identify areas where it may be able to reduce its tax liability.

The fourth part of the paper discusses the importance of maintaining accurate records of all debts. This will allow the business to track its debt liability over time and identify areas where it may be able to reduce its debt liability.

The fifth part of the paper discusses the importance of maintaining accurate records of all equity. This will allow the business to track its equity over time and identify areas where it may be able to increase its equity.

The sixth part of the paper discusses the importance of maintaining accurate records of all other financial information. This will allow the business to track its overall financial performance over time and identify areas where it may be able to improve its financial performance.



1 fellowships?

2 MISS CARPENTER: Yes, sir.

3 COMMISSIONER FIRESTONE: Would it be possible  
4 for you to give some consideration of how much money  
5 should be involved in such bursaries and in such  
6 fellowships and how many would you recommend and could  
7 that information be made available to us subsequently?

8 MISS CARPENTER: I might just comment on this  
9 point right now, if I may. There is a good deal of  
10 money now coming from national health grants, from  
11 the provinces, to nurses who are graduates mostly of  
12 the hospital schools to take the one year preparation  
13 in various areas of speciality. We would like, as an  
14 association, to give recognition to this assistance  
15 which has been of great help since it was instigated  
16 since the Second World War. The problem is, of course,  
17 it won't be good for training people for one year only  
18 and it ties the individual down to a specific province  
19 and sometimes it is needed elsewhere rather than the  
20 province from which the student was selected. We would  
21 be very happy to make a further comment on this problem  
22 in a subsequent item.

23 COMMISSIONER FIRESTONE: Thank you. In this  
24 subsequent submission if we could have amounts and  
25 numbers both at the undergraduate level and the graduate  
26 level.

27 MISS CARPENTER: Yes.

28 COMMISSIONER FIRESTONE: Thank you. Now, I  
29 have just a few general questions, some quickies; what  
30 are the views of your Association on the subject of







1 nursing residences, are you in favour or not?

2 MISS CARPENTER: I think we feel if the money  
3 that is now going into nurses residences could go into  
4 strengthening the educational program it would be a  
5 distinct advantage. I think we see in this country,  
6 although we know that residences have an academic value,  
7 a value educationally, I might say, rather than  
8 academic, an educational value, still we cannot afford  
9 to supply them to all the students in every kind of  
10 an educational program. It would seem to us desirable  
11 that if it is necessary for a student to live in  
12 residence by virtue of the fact she has not her home to  
13 live in or it is desired as an educational experience,  
14 those students who can afford to might well pay their  
15 way and those students who cannot afford to might well  
16 be given bursary assistance.

17 We know all but one province in 1961 where  
18 there are around 60 schools of nursing that over  
19 \$5 million is going into prerequisites such as room and  
20 board and other items. We feel if that money was  
21 redistributed so the students who need this help got it  
22 but the students who did not need it did not get it  
23 that the money might well be spent on strengthening the  
24 educational program.

25 COMMISSIONER FIRESTONE: You understand the  
26 universities are also building student residences  
27 generally?

28 MISS CARPENTER: Yes.

29 COMMISSIONER FIRESTONE: Would you not feel  
30 that with this tendency towards more people being trained







1 by the universities that these student residences might  
2 accommodate students of other faculties as well as  
3 nurses or are you still against the principle of nursing  
4 residences?

5 MISS CARPENTER: I cannot just follow you.  
6 The hospital nurses residence is going to meet the needs  
7 of the university, are the hospitals going to make their  
8 residences available to university students?

9 THE CHAIRMAN: No, you misunderstood.

10 COMMISSIONER FIRESTONE: You understand  
11 universities are building student residences?

12 MISS CARPENTER: Yes.

13 COMMISSIONER FIRESTONE: You recommend that  
14 more nurses go to university and so the student  
15 residences would be available to the nurses as well  
16 as other students in the universities; are you in favour  
17 of that?

18 MISS CARPENTER: Yes sir. We find, for  
19 instance, in our own school that we would like very much  
20 to make residences available as readily as possible and  
21 particularly in the first and second years. We do not  
22 urge the students to live in the residences as an  
23 experience all the way through their course; it is an  
24 educational advantage but I do not think it should be  
25 required of a student.

26 COMMISSIONER FIRESTONE: Have you any comments  
27 about the present program of nursing residences  
28 construction; do you feel it is adequate, inadequate or  
29 would you like to consider this and supply it as a  
30 supplementary comment?





1                   MISS CARPENTER: I saw a recent comment  
2                   that in Ontario itself about one-third of the schools  
3                   have adequate accommodation and they are speaking of  
4                   both residences and schools, I think. Whether this is  
5                   Canadian-wide or not, I do not know.

6                   COMMISSIONER FIRESTONE: Should we leave that  
7                   for you to obtain some comments at a subsequent time?

8                   MISS MacLENNAN: Some of the residences are  
9                   not for student nurses, they are for the staff nurses  
10                  so we would have to sort it out.

11                  COMMISSIONER FIRESTONE: Well, I am really  
12                  concerned with nurses residences which covers mostly  
13                  student nurses as well as residence nurses and we have  
14                  a program already in existence. All we want to find out  
15                  is, is the program working effectively, is it providing  
16                  adequate facilities or not and you are the best group  
17                  that we can ask the question of. May we have the  
18                  answer at a later stage?

19                  MISS CARPENTER: Yes.

20                  THE CHAIRMAN: Perhaps the relevant question  
21                  would be, do you recommend the providing of residences  
22                  for graduate nurses or registered nurse employees at a  
23                  hospital?

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MISS CARPENTER: Mr. Chairman, there is a tendency for the graduate nurses to desire not to live in residence and in a community where one can secure accommodation, it should not be necessary to consider building residences for graduate staff.

Now, there may be some exceptional communities where this is desirable but I would say the hospital should not go into the capital cost and expense of residences to house graduate staff and one questions whether they should go into big capital expense for housing students.

COMMISSIONER FIRESTONE: You realize that under the National Housing Act the bulk of the capital is provided by the Federal Government and the expectation is that the fees paid by the nurses would make this a self-liquidating corporation?

MISS CARPENTER: Yes.

COMMISSIONER FIRESTONE: So that the actual capital costs under the present National Housing Act to the hospitals are a comparatively small proportion of the total. I would like to ask you this question, Miss Carpenter: has the quality of nursing care suffered as a result of the introduction of the hospital insurance plan?

MISS CARPENTER: Our specialist on quality of nursing care is down here.

MISS CAMPION: In moving across the country one hears from the nurses that budgets have been reduced and consequently they are concerned about the quality of care.





1 Now, we have not made a study of the  
2 quality of care, nor have we at the moment any criteria  
3 on the quality of care, but one gathers the impression  
4 that with the reduction in budgets, there has been some  
5 reduction in the quality of care in some instances.

6 COMMISSIONER FIRESTONE: How would you  
7 define this reduction in quality of care?

8 MISS CAMPION: You say "define"?

9 COMMISSIONER FIRESTONE: How does one  
10 appreciate it? Would the nurse not be as nice to a  
11 patient under this scheme as under the previous arrange-  
12 ment? I am just trying to understand what is meant by  
13 reduction in the quality of care or do you have nurses  
14 say "I am sorry. I can't see you, I am busy."? How  
15 does that work in practice?

16 MISS CAMPION: I might be able to give  
17 you one instance that was given to me when we were  
18 discussing quality of care and the ratio of auxiliary  
19 personnel to graduate staff, the reduction of budgets  
20 and trying to assess how this has affected the quality  
21 of care; one nurse said that they had patients that they  
22 felt were not getting the amount of care that they  
23 should be getting, particularly this was in reference to -  
24 in this one situation - in reference to patients who  
25 are completely immobilized, completely dependent, who  
26 should perhaps be turned every hour, two hours, whatever  
27 it might be.

28 They need extra encouragement. They  
29 need a great deal of extra support, motivation, and so on.  
30 They felt they were not able to give this because of the







1 reduction.

2 COMMISSIONER FIRESTONE: Would you say  
3 then one way of measuring it is to look at the ratio  
4 between registered nurses and auxiliary nursing personnel  
5 on the basis that auxiliary nursing personnel have less  
6 training than registered nurses and could not possibly  
7 give them the same service? Is that your point?

8 MISS CAMPION: That is not the only  
9 factor.

10 COMMISSIONER FIRESTONE: It is not the  
11 only factor but is that one way of establishing whether  
12 there is a reduction in quality or not?

13 MISS CAMPION: It would be one factor  
14 I would think, yes.

15 COMMISSIONER FIRESTONE: Let's then  
16 discuss this one factor. Do you know whether this  
17 ratio has decreased or has changed materially the last  
18 two or three years?

19 MISS CAMPION: I haven't the figures  
20 that I could quote but judging by discussion as I move  
21 across the country I would feel that in many instances  
22 there has been an increase in the number of auxiliary  
23 personnel to the number of registered nurses.

24 This means that there is less supervision,  
25 less assistance given to the auxiliary personnel.

26 COMMISSIONER FIRESTONE: Would it be  
27 possible, Miss Carpenter, in your supplementary submis-  
28 sion to present these figures and any other comments  
29 you wish so that we have your assessment of this situa-  
30 tion?







1 MISS CARPENTER: Yes sir.

2 COMMISSIONER FIRESTONE: My last  
3 question is: has the Canadian Nurses' Association any  
4 views about a National Medical Care Plan to which the  
5 Federal Government makes a financial contribution but  
6 it would be administered by the provinces?

7 MISS CARPENTER: Mr. Chairman, Professor  
8 Firestone, I think we would like to leave our views as  
9 set out here. I could not give you the views on this  
10 subject as an Association.

11 We have no unanimity of opinion as to  
12 the method by which the needs of the people for health  
13 service should be met and I think that we certainly  
14 would wish to see people have access to the health  
15 service they need and the quantity and quality they need.

16 We do feel that yourselves, as members  
17 of the Commission and the experts that you have to  
18 consult, would be the ones to answer the method by  
19 which this might be achieved.

20 COMMISSIONER FIRESTONE: In other words,  
21 if I understand you correctly, Miss Carpenter, and  
22 please correct me if I didn't, your Association is in  
23 favour of comprehensive medical care service to become  
24 available to the people of Canada but you do not have  
25 any views as to how this should be brought about and how  
26 it should be financed?

27 MISS CARPENTER: Yes.

28 COMMISSIONER FIRESTONE: Is that your  
29 view?

30 MISS CARPENTER: Yes sir.





1 COMMISSIONER FIRESTONE: Thank you  
2 very much.

3 COMMISSIONER BALTZAN: Miss Carpenter,  
4 I just want to cover one thing that I overlooked; on  
5 page 33, paragraph 110:

6 "Recognizing the contribution of the  
7 nursing sisterhoods to nursing in  
8 Canada it is suggested that, all  
9 things being equal..."

10 Am I right when you say "all things being equal" that the  
11 standards, curriculum, period of time for training and  
12 the physical facilities - is that what you mean by "all  
13 things being equal"?

14 MISS CARPENTER: Yes sir. Mr. Chairman,  
15 we had a considerable discussion of this point in execu-  
16 tive before this brief was prepared. We recognize that,  
17 I think it is approximately 40% of the present nurses  
18 and nursing in hospitals are now religious sisterhoods  
19 and in some provinces we have under government a separate  
20 school system that is recognized and in some provinces  
21 we do not.

22 If there were a change in financing of  
23 nursing education, I think what we want to make known  
24 was that we would like to support the contribution of the  
25 nursing sisterhood and if a method of financing were  
26 found that would bring these schools under education,  
27 that if the sisterhoods should meet whatever criteria  
28 that were being suggested for schools, I think should  
29 have support for schools of this nature as well as non-  
30 sectarian schools.







1 COMMISSIONER BALTZAN: Exactly the same  
2 sort of benefits?

3 MISS CARPENTER: Yes sir. In view of  
4 the time, you may not want Sister to speak.

5 COMMISSIONER BALTZAN: Thank you very  
6 much.

7 THE CHAIRMAN: Do you wish to add anything,  
8 Sister?

9 SISTER MADELEINE: No, I don't think I  
10 would have anything to add. I think Miss Carpenter has  
11 explained it just about as it is.

12 THE CHAIRMAN: Thank you very much  
13 Miss Carpenter and Sister Madeleine. This, as has been  
14 said, is a very excellent brief, contains all material,  
15 factual information and the information you have given  
16 us here today which is very valuable.

17 MISS CARPENTER: I think we appreciate  
18 the opportunity to have these problems so well discussed,  
19 so thoroughly discussed. Thank you.

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1 MR. HALL: The next submission is that  
2 of the Canadian Highway Safety Council. The brief  
3 submitted will be filed as Exhibit No. 206.

4  
5 --- EXHIBIT NO. 206: Submission of the Canadian Highway  
6 Safety Council.

7  
8 SUBMISSION OF THE CANADIAN HIGHWAY  
9 SAFETY COUNCIL

10 Appearances: Dr. Wallace Troup  
11 Mr. W.A. Bryce  
12 Mr. Paul Gormley

13 MR. HALL: Appearing on behalf of the  
14 Canadian Highway Safety Council are Dr. Wallace Troup,  
15 who is Chairman of the Medical Advisory Committee of the  
16 Canadian Highway Safety Council and he is also Chairman  
17 of the Committee of the Canadian Medical Association  
18 dealing with the medical aspects of highway accidents.

19 Also appearing is Mr. W.A. Bryce, the  
20 Executive Director of the Canadian Highway Safety Council  
21 and Mr. Paul Gormley.

22 Mr. Bryce will present the summary of  
23 the brief and recommendations. Mr. Bryce?

24 MR. BRYCE: Mr. Chairman, with your  
25 permission, it is not my intention to read through this  
26 brief. I would like to read the foreword, the summation,  
27 and the recommendations and trusting to the degree to  
28 which you people did your homework, subject us to what-  
29 ever questions you feel are pertinent.

30 THE CHAIRMAN: There has been nobody  
punished for not doing homework yet.





1 MR. BRYCE: That is what I was afraid  
2 of.

3 The Canadian Highway Safety Conference  
4 name gave way, under pressure, to the name Canadian High-  
5 way Safety Council - its present name since August 24,  
6 1960.

7 At the risk of confusing the issues, at  
8 this point it should be mentioned that further responsi-  
9 bilities are vested in the Canadian Highway Safety  
10 Council as it also holds and nourishes a charter for the  
11 National Safety League of Canada. This organization has  
12 been largely inoperative since 1933. Pressure from  
13 provincial organizations has recently invited and encou-  
14 raged the reactivation of the National Safety League of  
15 Canada to provide leadership in the fields of home safety,  
16 child safety, recreational and water safety and farm  
17 safety. This task has been laid on the doorstep of  
18 C.H.S.C. and expansion is going forward. Thus it can be  
19 seen that safety in its broader aspects has even a  
20 broader claim to interest and support in the field of  
21 health services whether federal, provincial or local.

22 As you are aware sir, the British  
23 North America Act tends to place - I am ad libbing now,  
24 you won't find this in the brief - tends to place the  
25 matter of road transportation in the jurisdiction of the  
26 provinces which means, consequently, that the Federal  
27 Government can conveniently shelve any matters dealing  
28 with road transportation among which come the problems  
29 of highway accidents.  
30







1 THE CHAIRMAN: Not exclusively, because any  
2 conduct that is regarded as being criminal in this  
3 nature is considered wholly in the field of the  
4 federal government.

5 MR. BRYCE: I would agree with that; and  
6 if we can induce the public to regard misdemeanour on  
7 the highway as criminal --

8 THE CHAIRMAN: Drunk, impaired, these are all  
9 criminal offences under the Criminal Code.

10 MR. BRYCE: I mention this because this same  
11 problem leads the Department of Highways, who builds the  
12 roads, to fail to delegate to the Health Department  
13 the degree of responsibility which we feel should be  
14 theirs, and the purpose of our brief is to draw  
15 attention to the fact that it is the responsibility of  
16 the federal government and delegated down through the  
17 provincial governments to attack this problem as a  
18 problem that is epidemic.

19 Now, in summation I have said something along  
20 the same lines.

21 Safety programs cannot be operated on lip  
22 service. In the same way that we are all against sin,  
23 we are all in favour of safety, provided that its practice  
24 does not inhibit our personal behavior patterns.

25 Lack of financial support is symptomatic of the  
26 whole traffic problem today, and this is a sore point  
27 with those who work in the field, not only in the federal  
28 field but in the provincial field. It is true to say  
29 in Canada, and it is ironic that the economic losses of  
30 a single holiday weekend traffic toll would more than





1 cover the entire budget of highway safety organizations  
2 across Canada for half a decade. Tremendous economic  
3 losses resulting from traffic accidents are shared by  
4 all the people. Society is dependent upon automatic  
5 transportation. You can argue with that word "automatic"  
6 and change it to "automotive". Gordon Taylor is  
7 responsible for this phrase, "which leaves blood on  
8 our pavement, fills many beds in our overcrowded  
9 hospitals, demands space in our goals and darkens the  
10 lives of many families. It is sometimes forgotten  
11 that in the public health plan to which the federal  
12 government prescribes it pays a great deal of money  
13 toward the accident toll which it doesn't realize it is  
14 paying, because the beds that are occupied in hospital  
15 by accident victims would not require the federal  
16 subsidy if we could prevent these accidents. This  
17 disease, this by-product of our use of steel, cement  
18 and oil is epidemic. We need help in a vaccination  
19 process founded on the development of proper attitudes  
20 through adequate information, instruction and training.  
21 Toward that end we have segregated certain  
22 recommendations which bear on this particular subject,  
23 although there are many others which bear on the  
24 general problem which we don't introduce in terms of  
25 presenting them to you.

26 The implementation of these recommendations  
27 will be accelerated by help from the federal government  
28 or provincial government regulations.

29 A uniform driver licensing process which  
30 will include:







1 (a) Medical examination.

2 (b) Psychological interview or  
3 interrogation.

4 (c) Psychophysical tests

5 (d) Adequate road test in traffic.

6 Now, to a degree we have those in certain  
7 provinces now.

8 2. Periodic re-examination of drivers  
9 every five years -- a somewhat idealistic  
10 concept at the moment, but, nevertheless  
11 to be worked toward in the future.

12 3. Driver education and training for all  
13 young people as a prerequisite to  
14 application for a driver's licence.

15 4. Preparation in safety education for  
16 all teachers while attending teachers'  
17 colleges so that safety information and  
18 safe attitudes may be imparted formally  
19 or integrated suitably with other  
20 subjects.

21 5. Acceptance of the breathalyzer test  
22 conducted by qualified technicians  
23 as an accurate method of determining  
24 blood alcohol content.

25 6. Establishment that a blood alcohol  
26 content of .01 per cent be deemed  
27 evidence of an impaired condition.

28 Those are the subjects upon which we feel  
29 help from health departments in this country would  
30 strengthen our case.





1 THE CHAIRMAN: In No. 6, Mr. Bryce, you mean  
2 deemed evidence or conclusive evidence?

3 MR. BRYCE: We would like to see it regarded  
4 as conclusive evidence, but at the present time it is  
5 not accepted even as evidence, because a test may be  
6 refused. It is corroborative in its present operation.

7 Dr. Troup, who has been studying this matter  
8 for the Canadian Medical Association, may have comments  
9 on this point.

10 THE CHAIRMAN: Yes.

11 DR. TROUP: Mr. Chairman, the Canadian Medical  
12 Association Committee feel that diagnosis of drunkenness  
13 should not be made until it is based on a careful  
14 history, proper physical examinations and, if necessary,  
15 lab test.

16 THE CHAIRMAN: You mean a clinical test of some  
17 kind?

18 DR. TROUP: Yes, if necessary, and a lab test.

19 COMMISSIONER BALTZAN: I am glad to hear you  
20 say that, sir, because I think it is the common  
21 knowledge of everybody -- correct me if I am not right --  
22 that he who was not used to alcohol may take a sip and f  
23 dizzy and someone who is used to it may take a larger  
24 amount and feel all right; is that right? And the  
25 actual content in the blood is not the true picture of  
26 the coordination, or is it?

27 DR. TROUP: All the biochemical test does  
28 is tell you the content of alcohol in the blood at the  
29 time the test is taken.

30 COMMISSIONER BALTZAN: It doesn't necessarily







1 tell you the coordination.

2 DR. TROUP: Not necessarily. We think we need  
3 all three.

4 MR. BRYCE: Our position is that alcohol  
5 impairs physical performance, and when one takes alcohol  
6 and starts to drive one is not in the type of efficiency  
7 one would like to see in this country. Even though a  
8 150 lb. man may not show the same condition when he has  
9 taken alcohol as against another 150 lb. man, in most  
10 cases there will be a depressant effect, and we find  
11 in experimentation it is the lower concentration of  
12 alcohol from .05 per cent to .10 per cent than the  
13 concentration of .15 per cent up to .25 per cent, because  
14 the chances are that the man in the latter group will  
15 be so drunk that he will not attempt to perform.

16 COMMISSIONER BALTZAN: That all points to the  
17 fact that one should not rely on that alone, at least  
18 not justly do so.

19 MR. BRYCE: I think as Dr. Troup said we  
20 should not deal with that alone, it would be undemocratic.

21 COMMISSIONER GIRARD: Mr. Chairman, I would  
22 only like to say that I think I would be in favour of  
23 having the young people have training prerequisite  
24 to the application for a driver's licence. I can  
25 recall seeing in Finland in a park in the centre of  
26 the city some toddlers of five or six being given  
27 instructions on how to cross the street and being told  
28 what to do in driving automobiles, little kiddy cars,  
29 with a traffic policeman, and I thought they were  
30 starting very young, and I thought this would be a good







1 idea. I know in the United States highschool students  
2 have to take driving instructions, and I feel that this  
3 should be done a lot more in Canada too, because I  
4 think the teenagers are the ones who have more accidents  
5 and if we insisted that they should know how to drive,  
6 if they were taught and supervised I think we may have  
7 less accidents.

8 MR. BRYCE: If the health and physical  
9 aid program uniformly across the country demanded that  
10 certain safety studies be undertaken, and that was  
11 part of -- I am not talking about behind the wheel  
12 training --

13 THE CHAIRMAN: Pedestrian as well as driving?

14 MR. BRYCE: Yes. If those attitudes could  
15 be taught as they used to be in Ontario schools up to  
16 grade 9, and they were cancelled out with training  
17 in St. John Ambulance and Red Cross, and they returned  
18 to what we are pleased to call the three R's, and  
19 at the same time we had a tremendous expansion in  
20 extra curricular activities, music and gynasium and  
21 what have you -- we couldn't afford swimming tanks  
22 before, we have them there now, and their swimming  
23 skills will stay with them for a long time, maybe  
24 fifty or sixty years, but that doesn't apply to  
25 driving, even as a pedestrian.

26 COMMISSIONER VAN WART: Courtesy, is a  
27 good example.

28 MR. BRYCE: Courtesy is one of the most  
29 contagious things we can teach, and we can teach them  
30 courtesy and good sportsmanship at high school level,





1 teach them courtesy and sportmanship at the high  
2 schools levels. We can teach them nothing but academic  
3 subjects now; that is making it difficult.

4 THE CHAIRMAN: I suppose you could say that  
5 roads are being engineered so that they may be safely  
6 driven upon.

7 MR. BRYCE: Only eight to ten per cent of  
8 accidents, at the most generous computation could be  
9 attributed to road conditions; it is generally located  
10 at five per cent. The fact that a road is slippery  
11 is no excuse for an accident on the road in Canada,  
12 any more than if we wanted to use potholes as an  
13 excuse.

14 COMMISSIONER STRACHAN: Mr. Chairman, one  
15 question I would like to ask with reference to the  
16 breathalyzer test. Take two men of equal weight,  
17 if they consume a similar quantity of alcohol, will  
18 the breathalyzer test be identical?

19 THE CHAIRMAN: Mr. Bryce, do you wish to  
20 enter upon that discussion? There is, as you can  
21 appreciate, a great volume of research material, the  
22 studies which have been made, the particular detailed  
23 studies made by the R.C.M.P. in Ottawa, driving tests;  
24 there are books now written on the subject, various  
25 tests that have been made, experiments carried out over  
26 a long period.







lpw

1 DR. TROUP: Mr. Chairman, I have come  
2 here to support the Canadian Highway Safety Council,  
3 but I am chiefly concerned with the two last recommenda-  
4 tions.

5 THE CHAIRMAN: I was just wondering if  
6 you wanted to enter upon any academic discussion about  
7 the use of the breathalyzer?

8 DR. TROUP: Yes sir, I am prepared to  
9 do that, and might I say just this morning I have  
10 received from the Canadian Medical Association Journal  
11 the Report of the Executive Committee.

12 It states in No. 11:

13 "Alcohol and Driving. As much scienti-  
14 fic evidence has shown conclusively  
15 the increasing role of alcohol as an  
16 important factor in the cause of  
17 traffic accidents, the C.M.A. through  
18 its national and provincial organizations  
19 should advise the federal and provincial  
20 governments that it is unsafe for most  
21 persons to drive a motor vehicle with  
22 a blood alcohol level of 0.05% and for  
23 all persons at a level of 0.10%, and  
24 suggests that governments take necessary  
25 steps to utilize these standards in  
26 their law enforcement procedures.

27 The Committee recognizes further, that  
28 the breathalyzer test, carried out by  
29 properly trained technicians, is an  
30 accurate method of determining blood





1 alcohol levels, and recommends that the  
2 C.M.A. and its Divisions also bring  
3 this procedure to the attention of the  
4 federal and provincial governments and  
5 recommends that this test be used as  
6 a practical means of measuring blood  
7 alcohol in drivers of motor vehicles."

8 It was further proposed this recommenda-  
9 tion be incorporated in the C.M.A. Brief to the Royal  
10 Commission on Health Services. I understand that this  
11 will be presented when you meet in May. The Executive  
12 of the C.M.A. authorized me to speak this afternoon as  
13 Chairman of the C.M.A. Traffic Accident Committee, as  
14 well as this other hat I am wearing.

15 THE CHAIRMAN: Are you in a position to  
16 give us any idea of the percentage of accidents which  
17 are reputed to be attributable to the use of alcohol,  
18 and other accidents in which alcohol does not appear  
19 at all?

20 I mean, I was just wondering if the  
21 suggestion is that all the accidents are due to alcohol,  
22 or just what proportion ---

23 DR. TROUP: No.

24 THE CHAIRMAN: --- of this table on  
25 page 3 are we directing our attention to in discussing  
26 recommendations 5 and 6?

27 MR. BRYCE: On page 10 there is a comment  
28 made in that connection which shows the lack of conclu-  
29 sive evidence, where I say after having studied various  
30 authorities:







1 "Studies based upon fatal traffic  
2 accidents place the presence of alcohol  
3 as a contributing factor in anywhere  
4 from 25% to 60% of the deaths."

5 Now, that is based upon Attorney-General  
6 Departments across the country, and in Ontario it  
7 certainly is the Attorney-General's Department go as  
8 high as 60% of the fatal accidents are attributed in  
9 some degree to the presence of liquor.

10 THE CHAIRMAN: Is that what they say,  
11 or is the report that they make that liquor has been  
12 established to be present?

13 MR. BRYCE: Liquor is present. Not the  
14 conclusive and final reason ---

15 THE CHAIRMAN: You make the ---

16 MR. BRYCE: The jump?

17 THE CHAIRMAN: The jump into making it  
18 in some measure responsible.

19 MR. BRYCE: I think that is saying the  
20 same thing.

21 THE CHAIRMAN: Well, if it is I  
22 wouldn't understand it that way, but is that what you  
23 mean?

24 MR. BRYCE: That is what I would try  
25 to say, but the reason for the other ---

26 THE CHAIRMAN: An unopened bottle of  
27 liquor in a car is liquor being found at the scene of  
28 an accident?

29 MR. BRYCE: I mean the consumption of  
30 liquor. I see what you mean now.







1 THE CHAIRMAN: You see those figures,  
2 they build them up both ways.

3 COMMISSIONER STRACHAN: That is by the  
4 driver?

5 MR. BRYCE: Liquor consumed by the  
6 driver, or by the pedestrian if he happens to have been  
7 knocked over, but when it comes to the arbitrary decision  
8 on the part of a policeman that this man who has been  
9 injured had been drinking, more often than not the  
10 policeman does not make an entry on the report form,  
11 because he has no conclusive proof that he has been  
12 drinking, and the next appearance that man makes will  
13 be before the courts as an exemplary citizen with charac-  
14 ter witnesses.

15 Consequently, if we had our breathalyzer  
16 with an expert to prove that he had only .05 when the  
17 minimum is .10; on the other hand, if they take this  
18 breathalyzer test, as in Saskatchewan, you automatically  
19 accept that, accepting that licence means that you will,  
20 if required, take a breathalyzer test which will be used  
21 as corroborative evidence.

22 If we had that all across our country  
23 there would be far less driving after drinking than there  
24 is today.

25 THE CHAIRMAN: Do the figures in Saskat-  
26 chewan bear that out?

27 MR. BRYCE: : They bear it out better  
28 than any other province.

29 THE CHAIRMAN: I mean just the figures  
30 on the accidents?





1 MR. BRYCE: They do, yes.

2 DR. TROUP: In the Report from the  
3 Ontario Department of Transport, The Physical Condition  
4 of Drivers in Motor Vehicle Accidents from 1st January  
5 to 31st August, 1961, on the road:

6 "The Drinking Drivers in Fatal Accidents  
7 Particular attention has always been  
8 focused on the drinking driver and  
9 especially when involved in a fatal  
10 accident. Studies conducted in the  
11 U.S.A. on this subject have indicated  
12 that up to 50 per cent of fatal acci-  
13 dents have involved drinking drivers.  
14 Based on this study for Ontario, out of  
15 a total of 640 fatal accidents a drinking  
16 driver was reported in 160 or 25.1 per  
17 cent of the total fatal accidents. Our  
18 report is factual and the data derived  
19 from actual police reports. Of the  
20 160 drivers who had been drinking and  
21 in fatal accidents 80 were killed, in  
22 addition another 96 also met their  
23 deaths due to these accidents. The  
24 ninety-six killed were made up of the  
25 following classifications, 6 other  
26 drivers, 63 passengers (with the  
27 drinking driver and in other vehicles),  
28 23 pedestrians, 2 bicyclists, 1 motor-  
29 cyclist and one miscellaneous or a  
30 total of 176. This 176 represents 23.2







1 per cent of the total killed in traffic  
2 of 758 for the eight-month period."

3 THE CHAIRMAN: Are there similar figures  
4 for Saskatchewan?

5 MR. BRYCE: I am sorry, I can provide  
6 that to the Commission. We work through the Registrar  
7 of Motor Vehicles, which is our best source there, Mr.  
8 Christie.

9 COMMISSIONER STRACHAN: You mention  
10 the age group from 18 to 45 in particular. How does  
11 this relate to accidents in general, and to accidents  
12 attributed to alcohol? I don't find anything in your  
13 tables at the back to give this, I may be wrong.

14 MR. BRYCE: Because we knew that the  
15 Canadian Medical Association was going to supply some  
16 specific material on this subject we didn't supply the  
17 appendices to support that.

18 The age group from 18 to 45, of course,  
19 is the age group which covers the greatest number of  
20 miles, and the age group from 18 to 25 is the most lethal  
21 group in terms of accident and death.

22 I cannot give you any figures in rela-  
23 tion to that adult group showing the number of people  
24 who, having become impaired through alcohol, were either  
25 the cause or victim of accidents.

26 Those are things which a proper study  
27 in Canada of the subject would make possible. We can give  
28 you a real verdict on it, but it takes a lot of money to  
29 launch such a study, and we haven't been able to convince  
30 the Department of Health and Welfare, generous as they





1 have been, to launch into that field, but at this very  
2 time the Royal College of Physicians and Surgeons is  
3 in the process of promoting something along that line,  
4 and they hope for government help.

5 COMMISSIONER STRACHAN: What, in your  
6 estimation, is a trained driver?

7 MR. BRYCE: A driver who, prior to  
8 having been given a licence, takes certain lesssons  
9 requiring the full knowledge of rules of the road, good  
10 driving practice, his own physical capacity in terms of  
11 driving, having been taught compensation for these short-  
12 comings, if there are any.

13 If a man is colour-blind, he can be as  
14 good a driver as his neighbour, but he should know he is  
15 colour-blind.

16 If a man has slow reaction, he can be  
17 as good a driver as his neighbour, but he should know he  
18 has slow reaction.

19 Tests are not applied to the fullest  
20 extent, and standardized across Canada. The provinces  
21 are stepping the thing up gradually, and in the last 10  
22 years there has been a terrific improvement, but it has  
23 not been supported by the health people, who say this is  
24 a health problem, but by the medical administrator trying  
25 to put through legislation which will regiment the driver  
26 to improve himself.

27 COMMISSIONER STRACHAN: Would you agree  
28 then, sir, that even a driver who is recognized as being  
29 properly trained would not reduce or eliminate, to use  
30 some of your words, apathy, self-consciousness,







1 indifference, impatience, emotional instability?

2 MR. BRYCE: I believe that is one of  
3 the things that the future will have to outline. Of  
4 course, it is not too easy to say to a man when he  
5 applies for a driver's licence, "You are a potential  
6 killer because of your inability to control your temper,  
7 therefore we won't give you a licence", because he has  
8 not broken out yet as a bad driver, but subsequently in  
9 our driving examination we should be able to put a red  
10 ticket on that man and follow him through, so that 10  
11 years later, instead of killing someone, we could look  
12 at him and tell him.

13 If a man has poor vision, or emotional  
14 instability to the point where you don't think he can  
15 control himself, because his family life shows that, I  
16 think there should be a controlling ticket placed on  
17 that man when he gets his licence.

18 You may say that is undemocratic, but  
19 the medical people will go for it.

20 COMMISSIONER STRACHAN: To the point  
21 where one man will make a decision?

22 MR. BRYCE: No, I don't think so. In  
23 British Columbia they have a board of three. In Ontario  
24 a medical board of six or seven, which meets regularly  
25 to pass on special cases.

26 COMMISSIONER VAN WART: In England  
27 they have a learner plate which they put on their cars,  
28 an L, I think it is.

29 MR. BRYCE: They carry that for a year,  
30 don't they?







1 COMMISSIONER VAN WART: Some of them  
2 carry them for years, and other drivers shy away from  
3 them.

4 MR. BRYCE: Keep clear because of this  
5 special licence.

6 COMMISSIONER BALTZAN: Gentlemen, we  
7 are not looking for any criticism. We are looking for  
8 information, and Dr. Troup, in telling your statistics  
9 you spoke there of drinking drivers. You didn't use  
10 the word drunken drivers. Do you mean people who consume  
11 alcohol?

12 DR. TROUP: The statement that I read?

13 COMMISSIONER BALTZAN: Yes.

14 DR. TROUP: That was the drinking driver.  
15 The driver was reported as having been drinking.

16 COMMISSIONER BALTZAN: Having taken a  
17 drink before he started out?

18 DR. TROUP: No, it is here on the  
19 second page:

20 "Out of a total of 640 fatal accidents,  
21 a drinking driver was reported in 160,  
22 or 25.1% of the total fatal accidents.  
23 Our report is factual, and the data  
24 derived from actual police reports."

25 COMMISSIONER BALTZAN: In other words,  
26 he is known to have taken alcohol, either during or just  
27 before he started? That is what they mean by drinking  
28 drivers?

29 DR. TROUP: Yes, and found not to have  
30 been sober when the police arrived at the scene of the





1 accident. I take it as meaning that.

2 COMMISSIONER BALTZAN: One other ques-  
3 tion, with regard to the blood alcohol, knowing the  
4 metabolism of alcohol etc.; an accident occurs 20 miles  
5 out, and it takes an hour to bring the man in, and then  
6 the blood test is performed, say, an hour later, and  
7 during that time there may be a lot of dissipation of  
8 that content in the blood. How do you correlate the  
9 time the test is taken with the time of the accident?

10 THE CHAIRMAN: As Dr. Troup will tell  
11 you, you can work that out scientifically.

12 MR. BRYCE: Roughly, sir, it is one  
13 ounce per hour of liquor as we know it; that is to say,  
14 Canadian rye whiskey, which is 40% proof, which, if  
15 reduced to a scientific minimum, would be one-third of  
16 an ounce of alcohol in the body, so if you took one-third  
17 of an ounce on the hour every hour for 24 hours, you  
18 wouldn't build up a concentration which would impair you  
19 to a legal degree.

20 COMMISSIONER BALTZAN: Which answers my  
21 question, that the content at the time would be lower  
22 than at the time of the accident. I have one final  
23 question, and this is this, which may be rather a naive  
24 thing, but it is a fact that we have speed limits of 60  
25 miles an hour, maybe up to 70 in some places, and yet  
26 cars are being manufactured to run at 110 per hour, and  
27 higher than that; ones of 200 horsepower.

28 Is there some attention being given to  
29 that incongruity in our safety measures?

30 MR. BRYCE: I think the evidence is







1 strongly in the direction that attention is being given  
2 to it.

3 Ten years ago there was a horsepower  
4 race advertised by the manufacturers, and people in the  
5 safety field raised such a hue and cry about it that  
6 you haven't heard advertised over the radio a two or  
7 three hundred horsepower boast being made by an auto-  
8 mobile company in years.

9 The evidence that the compact car is  
10 coming into prominence; it is impossible for the compact  
11 cars to travel at the same speeds as other cars over any  
12 length of time.

13 You can take a Volkswagen and put it  
14 up to 80 miles an hour if you want to. You can take  
15 another car and put it up to 110.

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1 Now, the speeds on the highways are becoming  
2 less lethal than they were even though highways are  
3 built better than they were formerly. The provinces,  
4 except British Columbia, because of their Minister of  
5 Highways, is taking a second look at the sixty and seventy  
6 miles an hour speeds and legislating downwards in their  
7 effort to cut down death on the highways. People are  
8 beginning to accept this. If anyone asks us what the  
9 policy is we say the speed on the highways should be  
10 fifty. We have a case of last year in Ottawa, No. 17  
11 Highway between here and Montreal where the speed  
12 was wrongly set at 70 miles an hour range. If we  
13 are asked what the speed should be in a four lane  
14 highway, limited access, we say 60. In some provinces  
15 it is higher and in some states it is unlimited so we  
16 have decided on the 60 miles an hour as our policy.

17 COMMISSIONER BALTZAN: That answers my  
18 question.

19 COMMISSIONER FIRESTONE: On page 12, paragraph  
20 1, your Canadian Highway Safety Council recommends:

21 "A uniform driver licensing  
22 process."

23 How would you recommend that such a uniform  
24 driver licensing process be achieved?

25 MR. BRYCE: We do have the Association of  
26 Motor Vehicle Administration which is combined with  
27 transport board officers and they meet at different  
28 times during the year. One of the reasons which they  
29 meet is to compare the very specifications to which  
30 I refer and over the years I mentioned the visual acuity





1 requirement, they established on a uniform visual acuity  
2 of 20/40 with the exception of Nova Scotia which is  
3 20/60 and which I think will be changed as the result  
4 of the various conferences to which I referred. If  
5 extra pressure is put on asking that these uniform  
6 licensing processes be the same in every province,  
7 just like the load limits, I think we would legislate  
8 to conformity.

9 COMMISSIONER FIRESTONE: Who could put on  
10 that pressure?

11 MR. BRYCE: That is a problem. I have not  
12 got an off-the-cuff answer because of our division of  
13 authority between the road framework under the British  
14 North America Act and our health programs under the  
15 National Health and Welfare.

16 COMMISSIONER FIRESTONE: This is under the  
17 provincial road program and also under federal  
18 jurisdiction. If interprovincial road traffic is  
19 under federal jurisdiction can you visualize any  
20 specific proposal that would achieve your objective?  
21 You realize that you are making a submission to a ---

22 THE CHAIRMAN: I wonder if you have made an  
23 assumption that is not borne out in fact that  
24 Interprovincial traffic is under federal control.

25 MR. BRYCE: There are certain conventions  
26 accepted in the province and under provincial operation  
27 in the trucking field, when it comes to legislating  
28 the driving licensing you are in a different category.

29 THE CHAIRMAN: Weight and everything else.

30 MR. BRYCE: When it comes to legislating







1 trucking with vehicles you have relationships to the  
2 point where Alberta has just changed their load  
3 requirement to a point where licenses between Alberta  
4 and Ontario have changed the load limit to save a  
5 \$700.00 or a \$800.00 fee for certain tractors.

6 COMMISSIONER FIRESTONE: The question  
7 still before us is, is there anything within the  
8 federal jurisdiction with any provision or arrangement  
9 that can be used to achieve the objective which you  
10 have indicated in paragraph 1? As you realize, this is  
11 a Royal Commission advising the federal government  
12 and while we are in sympathy with your objective we  
13 would like to get some advice on how this objective  
14 can be put into practice as far as the federal  
15 government is concerned.

16 MR. BRYCE: I realize that is a very practical  
17 request and I am only sorry that I cannot give you  
18 chapter and verse at the moment. Would you permit me  
19 to have my people make a study and come up with  
20 something definite before the Commission because I  
21 realize that is something that should happen.

22 THE CHAIRMAN: You are talking about a uniform  
23 license?

24 MR. BRYCE: About a driver's license.

25 THE CHAIRMAN: Uniform requirements for  
26 drivers' license?

27 MR. BRYCE: It has a very wide connotation.

28 COMMISSIONER FIRESTONE: We would be very  
29 happy if you could give us some written submission  
30 supplementary dealing with this point.





1 THE CHAIRMAN: There is the mechanism of the  
2 Uniformity of Legislation Commission.

3 MR. BRYCE: We just had the uniformity for  
4 roads, signals, markings, translated into French and  
5 taken into Quebec and I think we should go one step  
6 further.

7 THE CHAIRMAN: In Europe with national  
8 entities rather than provinces they have been able to  
9 come up with the sort of continent-wide road formula.

10 MR. BRYCE: A conventionality that is  
11 accepted.

12 COMMISSIONER FIRESTONE: We would appreciate  
13 any subsequent submission you would wish to make on this  
14 point.

15 May I now turn to paragraph 3 on the same page  
16 in which you recommend:

17 "Driver education and training  
18 for all young people as a prerequisite  
19 to application for a driver's license."

20 Would you recommend that such a course be  
21 given on a compulsory basis in highschools, vocational  
22 schools, etc., where young people between 14 and 17 or  
23 18 would be in attendance?

24 MR. BRYCE: There is an interesting way of  
25 getting around that. I hesitate to do anything on a  
26 compulsory basis in this particular framework. In  
27 four of the states in the United States a youngster, a  
28 young person cannot get a license under the age of 18  
29 unless and until he has had a standardized driver  
30 training course. I would welcome, and I am sure a lot







1 of our people would, such a regulation in Canada. You  
2 see, in some provinces you get a license at 17, and in  
3 some it is 16; at least there should be uniformity  
4 when a youngster should get a license and when a parent  
5 should have to contend with that problem. In Newfoundland,  
6 for instance, it is 17 but the youngsters, a great many  
7 of them, are able to handle a vehicle and they handle  
8 a vehicle long before they are 17 without a license  
9 because enforcement bodies are not able to check them.  
10 However, if we had such a rule that a young person  
11 until 18 could not have a license unless he had a  
12 standard course, that would force into existence the  
13 standard course which we want. I am not in a position  
14 to say they should be appended to our present school  
15 system or added to our motor vehicle license system  
16 under the highways department or placed on a municipal  
17 basis. My problem is how a driver can be trained  
18 and the education people say education costs us too much  
19 money now, therefore, we have to be careful how we load  
20 extra funds onto the educational responsibility.

21 COMMISSIONER FIRESTONE: Have you any specific  
22 recommendations under paragraph 3 how this driver  
23 education and training should be achieved?

24 MR. BRYCE: Yes, we would like to see a  
25 requirement that every youngster before he gets a  
26 driver's license should take a standard driver's license  
27 course given by adequately trained teachers either  
28 within the framework of the school or, assuming that he  
29 has had to leave school at 16 and does not catch that  
30 within the school, then underneath other auspices which





1 are properly authorized. That would be our recommend-  
2 ation.

3 COMMISSIONER FIRESTONE: In the subsequent  
4 submission which you are going to make could you also  
5 elaborate on what you would consider an adequate  
6 training and vocational course?

7 MR. BRYCE: We have that drawn up and we can  
8 prepare that for you on a national basis. We are at  
9 the present time administering funds to train teachers  
10 in every province so that there will be a standardized  
11 presentation.

12 COMMISSIONER FIRESTONE: My next question is,  
13 would you be in favour of using seat belts in cars on  
14 a compulsory basis?

15 MR. BRYCE: Not until sufficient public  
16 opinion would endorse the requirement, otherwise we  
17 would defeat our own purpose. It is our purpose to  
18 so promote seat belts that the majority of the people  
19 in a community shall want them, then and not until then.  
20 We do not feel we can force this down their throats.  
21 This is our policy at the moment.

22 COMMISSIONER FIRESTONE: Have you had  
23 evidence in support of the use of seat belts reducing  
24 the number of accidents, fatal and otherwise?

25 MR. BRYCE: Yes, and perhaps I should quote  
26 Saskatchewan where they have evidence that forty of  
27 the accidents last year which were fatal would not have  
28 been so had a seat belt been introduced. Into our  
29 office every week we have a series of accidents which  
30 are recorded either in the newspapers or by private







1 submission show where a seat belt would have been  
2 advantageous. It has gone to a point where the  
3 critical aspect was introduced in one of the papers,  
4 had this man been wearing a seat belt he would not have  
5 been decapitated.

6 COMMISSIONER FIRESTONE: What is being done  
7 to encourage the use of the seat belt? You were  
8 saying earlier perhaps if a certain ratio of Canada's  
9 population should use seat belts and after passage of  
10 time they become compulsory, is this stage far ahead?

11 MR. BRYCE: It is in the foreseeable future.  
12 In the last two years the acceleration of the  
13 development of the use of seat belts has been very  
14 substantial. As of the present moment the National  
15 Council of Women with 750,000 members is espousing  
16 what is called a crusade for safety or a campaign for  
17 safety in which they are going all out to induce the  
18 local dealer to put seat belts in his demonstration  
19 cars, to induce husbands to purchase seat belts, to  
20 induce through their own organization the development  
21 of seat belts. This is something very unusual to  
22 have the National Council of Women espouse a specific  
23 cause of that kind and we were very fortunate they  
24 undertook that phase and we are very grateful that they  
25 did.

26 Then we have Canadian Standards established  
27 by the Canadian Standards Association which are the  
28 Committee established by the federal government and it  
29 has passed on the S.A.E. J.4 which is the accepted  
30 standard in the United States. This is not going hog







1 wild, we are not having paper mache seat belts sold  
2 to us.

3 COMMISSIONER FIRESTONE: Would you say another  
4 five years?

5 MR. BRYCE: I would say ten years, there is  
6 no use being over-confident.

7 COMMISSIONER FIRESTONE: My last question  
8 is, is there much research being done in the field of  
9 highway safety?

10 MR. BRYCE: In Canada?

11 COMMISSIONER FIRESTONE: In Canada?

12 MR. BRYCE: I would say no.

13 COMMISSIONER FIRESTONE: Has your Association  
14 a recommendation with respect to increasing this type  
15 of research in Canada and if you do not have it ready  
16 at the moment because it is a new subject not covered  
17 in your brief, would it be appropriate to ask you to  
18 consider this further and let us have your views in  
19 your supplementary submission?

20 MR. BRYCE: We would be very glad to do that.  
21 Dr. Troup may have some comments on that point, I  
22 think he has, with regard to research.

23 DR. TROUP: In May 1959 Dr. Elliott  
24 organized and inspired a national conference on the  
25 medical aspects of driving accidents and these are the  
26 proceedings of this conference and it was decided,  
27 arising out of the sessions that there should be formed  
28 in Canada a national body to encourage coordinating  
29 research to all the medical aspects of traffic  
30 accidents. That is May 1955.





1 I do not think this body - this founda-  
2 tion, got a charter and it has never had any money. It  
3 has never undertaken any research project. We suffer  
4 very badly in these fields, those of us who are working  
5 in this field, because we are unable to do firsthand  
6 research.

7 This meeting Mr. Bryce referred to in  
8 Ottawa about two weeks ago was attended by representa-  
9 tives of the Canadian Automobile Association, the Royal  
10 College of Physicians and Surgeons, the Canadian Medical  
11 Association and the Medical Research Council, the  
12 Federal Department of National Health and Welfare and  
13 we met and talked for a whole day.

14 We produced no money. I left the  
15 meeting. I reported to the Canadian Medical Association  
16 that I could see no signs of any money coming. You  
17 cannot do this type of research without funds and we  
18 are particularly anxious that we bring this need before  
19 you as a Commission because in the first place, this is  
20 in your terms of reference and we are stymied without  
21 help.

22 There are one or two pieces of research  
23 work being done into children's accidents - children's  
24 deaths and traffic accidents, in Vancouver, by Professor  
25 Reid and retrospective study of two years' accidents in  
26 Montreal has been started. Never finished. Started  
27 about three years ago and never finished.

28 The Ontario Medical Association conducted  
29 a year's study of ambulance service communications and  
30 emergency facilities in hospitals in the east end of







1 Ontario. The report was presented to the Provincial  
2 Government and we are awaiting their action but no  
3 signs of anything happening at all.

4 Those of us in this field, we are  
5 very much concerned because you are also - I see you  
6 have terms of reference "Priority". Mr. Chairman, gentle-  
7 men, I would put this problem of traffic accidents at  
8 the top of your priority and I say that after having  
9 read so many of the proceedings that you have held  
10 throughout the rest of Canada so far.

11 We all know that people are killed  
12 every day but it should be impressed on the record that  
13 the leading cost of life in this country today is the  
14 result of accidents, accidents of all kinds and that  
15 traffic accidents account for about half of them.

16 This last year there were killed, last  
17 year, 1961, 3,390 were killed. 97,703 people were  
18 injured and there were 265,000 accidents.

19 These three figures; the killed was up  
20 3.5%, the injured up 8.1% and the number of accidents  
21 were up 7.4%.

22 In the brief there are statistics for  
23 14 years but if we sit back complacently and just look  
24 at this year and don't look forward, we miss a point.

25 If we take a straight line projection  
26 to 1980, which the Canadian Medical Association, I under-  
27 stand, has done in its manpower studies, if we take a  
28 straight line projection from 1956 to 1961 and project  
29 that into 1980, the number killed in Canada would be  
30 4,250 and if we did that for the number injured, the





1 number would be 193,000 would be injured.

2 This is not out of line with the figures  
3 in the last 14 years as we see the thing growing.

4 We would like to put this on record  
5 because as you mentioned a few moments ago, you are a  
6 federally-appointed Commission and you are expected to  
7 give advice to the Federal Government.

8 The Federal Government is very much  
9 concerned with this problem of traffic accidents and  
10 has been for years and we believe, particularly the  
11 Medical - the Canadian Medical Association - we believe  
12 that a breakthrough in this sorry picture is most likely  
13 to come through a realistic approach to legislation  
14 with regard to drinking drivers.

15 Now, they comprise a small number but  
16 they are a very important number particularly if you  
17 read statistics from the States and from other countries.

18 We have not very accurate statistics in  
19 this country and that is where we are at a disadvantage  
20 but it happens there are drinking drivers in this country.

21 We would like your help. We would like  
22 you to approach the Government as the Canadian Medical  
23 Association has approached the Department of Federal  
24 Justice.

25 The public is not going to ask for it.  
26 They are apathetic. There is inertia around. What is  
27 everybody's business is nobody's business but the Canadian  
28 medical profession cannot take this responsibility; last  
29 year being called to treat no fewer than 97,703 victims  
30 of traffic accidents.







1                   Some of these will require extensive  
2 treatment and a great deal of rehabilitation as Dr.  
3 Van Wart would agree. I am sure you would and Dr.  
4 Baltzan.

5                   Many of these cases would take up a  
6 great deal of time. The situation is such that it is  
7 time for action.

8                   In 1950, I have studied and looked up  
9 the Hansard and I found some pretty good witnesses to  
10 come to my support. I found Mr. Diefenbaker saying in  
11 June 1950:

12                   "I am not going into the clinical  
13 argument now although I am in a  
14 position to do so."

15                   They were then discussing changes in  
16 the Criminal Code, which they changed, and we have 11  
17 years of experience but we know the gaps that still  
18 exist.

19                   "There are those who will say that  
20 it means some invasion of one's  
21 liberty. Looking at it from the  
22 point of view of one who, with few  
23 exceptions, has invariably been  
24 engaged on the defence side, my  
25 answer is that I do not believe  
26 any question of the liberties of  
27 the subject arises when a person  
28 who has been in an accident which  
29 was obviously due to his negligence,  
30 and who apparently is under the







1 influence of liquor, is asked to  
2 breathe into a balloon with a view  
3 to determining once and for all the  
4 question whether or not the degree  
5 of his intoxication was such as made  
6 it dangerous for him to be on the  
7 highway. More than that I will not  
8 say."

9 And then two pages later he said:

10 "I believe in personal liberty,  
11 individual freedom and the rights  
12 of the accused, but as I see it no  
13 man has a right to raise the defence  
14 that his liberties are going to be  
15 interfered with by asking him to do  
16 a thing which will mean the applica-  
17 tion of no unnecessary force to his  
18 person, will give him an opportunity  
19 to establish his innocence if he is  
20 innocent, and on the other hand will  
21 not allow the parade one sees today  
22 in the courts of this country of  
23 those who, stumbling and staggering  
24 after an accident has taken place,  
25 find that there is no part of the  
26 Criminal Code more honoured in the  
27 breach than in the observance in so  
28 far as conviction is concerned."

29 He spoke further in 1951, he said:

30 "I realize the difficulties. I did





1 when I suggested on more than one  
2 occasion in the house that the breath  
3 test, the urine test and the blood test  
4 should be allowed. I realized that  
5 there would be an interference with  
6 the individual's rights by the taking  
7 of those tests. But drunken driving  
8 has become a serious matter menacing  
9 the lives of hundreds, if not thousands,  
10 of people within our country and  
11 requires very drastic action."

12 When he spoke in 1951 he would have had  
13 the figures perhaps of 1950 and there were killed 1,975  
14 and this last year 3,390 killed.

15 The situation was bad then. It is  
16 rapidly deteriorating. Mr. Garson, who was the Minister  
17 of Justice at the time, he had something to say:

18 "What is the main purpose of legisla-  
19 tion directed against driving after  
20 drinking? Surely it is to eliminate  
21 drinking as a cause of motor accidents  
22 and motor deaths.

23 It is now scientifically established  
24 that alcohol will impair the efficiency  
25 of a driver so that he does not drive  
26 at all with his normal ability, even  
27 though the degree to which he is under  
28 the influence of liquor may fall short  
29 of complete intoxication."

30 Then this was important from the Minister







1 of Justice at that time; he said:

2 "All the scientists seem to agree that  
3 impairment starts at around .05 per  
4 cent..." -

5 this, Mr. Chairman, gentlemen, is the figure recommended  
6 by the World Health Organization Committee on Alcohol  
7 in Traffic, by the British Medical Association and now  
8 by the Canadian Medical Association and this is a figure  
9 that is being aimed at quite effectively in a number of  
10 the States across the border.

11 COMMISSIONER FIRESTONE: Thank you,  
12 Dr. Troup. If I understand you correctly, you are in  
13 favour of the principle of doing more research in the  
14 field of highway safety as suggested. Mr. Bryce has  
15 indicated he would be in favour as well. That was the  
16 view which you expressed?

17 DR. TROUP: Yes, but if people are  
18 being killed every day on our streets, we would be  
19 grateful if this Commission would support the Canadian  
20 Medical Association and the Canadian Highway Safety  
21 Council in approaching the Federal Government to make  
22 such changes in the Criminal Code as would stimulate  
23 this research.

24 Today, you ask us how many accidents  
25 are due to drinking drivers. We have no way of accurately  
26 finding out. We can make a study, if we had permission  
27 to take breath tests in an area where we would designate  
28 a study to be made and at the same time we would deter  
29 people from driving.

30 This word "deterrent" has appeared many





1 times here, I am sure, but the very fact that a driver -  
2 if a driver knew that he was behind a wheel on a highway  
3 and he knew he had taken too much, the very fact that he  
4 knew he could be stopped and he was breaking the law  
5 without being involved in an accident just the same as  
6 he would be breaking the law if he were driving without  
7 care and the safety required, but the law as it stands  
8 at present cannot be enforced without an accepted test  
9 and we recommend the breathalyzer.

10 Also, we have to study, we do not have  
11 to study but arbitrary levels of complete alcohol have  
12 to be studied and I was glad to quote Mr. Garson accep-  
13 ting the figure of .05 as the upper limit.

14 I do not think anything has happened  
15 since he made that statement to show there is anything  
16 wrong with it.

17 COMMISSIONER FIRESTONE: Thank you,  
18 Dr. Troup. Mr. Bryce, just to bring this discussion to  
19 an end, as far as the research program is concerned,  
20 would it help you if I suggested four specific aspects  
21 of the question that you may wish to cover in your subse-  
22 quent submission?

- 23 (1) What kind of studies would you  
24 visualize under such a research program?
- 25 (2) Who should undertake such studies?
- 26 (3) How much money should be spent  
27 annually on such research?
- 28 (4) Where should this money come from?
- 29 (5) How should such funds be admini-  
30 stered?







1 Would this be convenient to you, sir?

2 MR. BRYCE: It certainly will be con-  
3 venient for us to do that. The answers may not be  
4 quite as palatable to the Government as you might wish  
5 but we will certainly ---

6 COMMISSIONER FIRESTONE: We are just  
7 here to obtain your views and if the Safety Council of  
8 Canada cannot advise us on what this research program  
9 should be in the field of research on highway safety  
10 and other safety measures, where we can get this advice?

11 MR. BRYCE: We are very glad to attempt  
12 that responsibility at the outset. At least, try to  
13 start an analysis.

14 COMMISSIONER FIRESTONE: Thank you  
15 very much.

16 MR. BRYCE: One thing, sir, that might  
17 interest you, part of it is in the brief but I think it  
18 strikes home to the place where responsibility lies.

19 There are 40 communities in Canada  
20 with a population of over 40,000 and those cities have  
21 49% of the population of Canada and they are responsible  
22 for 16% of the deaths, traffic deaths, in Canada.

23 Now, that is an interesting thing, I  
24 think. In other words, our deaths are taking place in  
25 the smaller communities, on the highways outside the  
26 cities, places where municipal governments cannot  
27 reach them.

28 Provincial Government must reach them  
29 by legislation.

30 Another thing I might say, while we







1 haven't got research, we have a good deal of statistical  
2 analysis because of the co-operation of the Chiefs of  
3 Police all across the country.

4                   There are 240 cities and towns in  
5 Canada with a population of over 5,000 people. All but  
6 three of these reported to us dutifully during the year.  
7 We were able to compile certain statistics. These have  
8 been completed since the brief went in. They can be  
9 made available to any that are interested but in that  
10 we find 85 of these 240 cities completed the whole year  
11 without a single traffic fatality.

12                   That is 85 cities and they were all  
13 over 5,000.

14                   The next point we found remarkable was  
15 that of the 240 cities and towns representing a population  
16 of within 50% of 10,000,000, which is 54% of our new  
17 population total of 18,250,000, they were responsible -  
18 although 54% of the population was there, they were only  
19 responsible for 23% of the traffic deaths.

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1 When you get down to a 5,000 population you are getting  
2 down very small. So 70 per cent of the deaths were  
3 taking place on the highways across the country. We  
4 can't even blame the railways because they were only  
5 responsible for 1 3/4 per cent. So we can get  
6 certain deductions from this thanks to these statistics  
7 which we have only been able to deduct in the last  
8 five years.

9 THE CHAIRMAN: Thank you very much, Mr. Bryce,  
10 Dr. Troup, and Mr. Gormley. The subject of traffic  
11 safety is a large one, and we are very grateful to  
12 have your assistance here this afternoon.

13 MR. BRYCE: Thank you, sir.

14 THE CHAIRMAN: We will rise for a few minutes.  
15 ---Short recess.

16 MR. HALL: Mr. Chairman, appearing for the  
17 Ottawa General Hospital are the Reverend Mother St.  
18 Philippe, Dr. Laurier, the Medical Director of the  
19 Hospital, Sister Marie Joseph, the Administrator of the  
20 Hospital, and Miss Simard, who is Director of the  
21 Social Services Department of the Hospital.

22 The Ottawa General Hospital has no written  
23 submission, and they are appearing in response to a  
24 letter sent by yourself as the Chairman wherein you  
25 indicated that the Commission was interested in learning  
26 more about the utilization of hospital facilities in  
27 this province and the relative need for active,  
28 convalescent and chronic beds and rehabilitation  
29 facilities, and it was suggested that the representatives  
30 of the Ottawa General Hospital could assist the







1 Commission in getting their views on the subject and  
2 particularly in regard to the use of hospital beds,  
3 the length of stay of patients, waiting periods until  
4 admission, beds not used for any reasons and any  
5 information relative on the subject of making the  
6 most efficient use of hospital facilities, beds,  
7 waiting rooms, diagnostic facilities, and so forth.  
8 It was also suggested that if there were any  
9 recommendations as to how the daily patient could be  
10 reduced, such as chronic, convalescent, rehabilitation  
11 facilities, these suggestions would be put forward.

12 I understand there hasn't been sufficient  
13 time from receipt of the letter to get full information  
14 or detailed information from the hospital records.  
15 Mother St. Philippe and the delegation are quite  
16 willing to give any information they can in response  
17 to any questions by the Commission. I understand that  
18 is the position.

19  
20 SUBMISSION OF OTTAWA GENERAL HOSPITAL

21 APPEARANCES:

22 Reverend Mother St. Philippe

23 Dr. Laurier

24 Sister Marie Joseph

25 Miss Simard

26 DR. LAURIER: Mr. Chairman, I thought we  
27 should excuse ourselves for not presenting anything in  
28 in writing, but there was a change in the Ottawa  
29 General last week and, of course, at the time Mother  
30 St. Philippe had to be away for about three weeks and





1 the new Administrator, who was the assistant  
2 administrator before, was just appointed and started  
3 out today as Administrator, although she has been in  
4 the hospital for over four years now. We do want to  
5 excuse ourselves for not having a written submission.

6 THE CHAIRMAN: We are grateful to you,  
7 Reverend Mother, for coming and yourself, Dr. Laurier,  
8 and we may be able to get the information as accurately  
9 as you are able to give it just as well had it come  
10 in a written submission.

11 We are concerned with the utilization of  
12 hospital facilities, both the utilization in relation  
13 to the hospital, the function the acute hospital is  
14 intended to perform, and whether there is any  
15 deficiency in that utilization through retention in the  
16 hospital of those who perhaps should be somewhere  
17 else or where utilization of hospital facilities  
18 solely for diagnostic purposes might be done in an out-  
19 patient department.

20 Now, how many beds are there in the hospital?  
21 What is your bed capacity?

22 REVEREND MOTHER ST. PHILIPPE: 628 at the  
23 present time.

24 THE CHAIRMAN: That is active ---

25 REVEREND MOTHER ST. PHILIPPE: That is  
26 active beds.

27 THE CHAIRMAN: And the hospital, is it wholly  
28 an acute --

29 REVEREND MOTHER ST. PHILIPPE: That is right,  
30 active beds only.





1 THE CHAIRMAN: You don't have any section for  
2 convalescents or long-stay or anything of that kind?

3 REVEREND MOTHER ST. PHILIPPE: Chronicles, no.  
4 We send them over to St. Vincent's Hospital.

5 THE CHAIRMAN: Is that entirely your  
6 organization?

7 REVEREND MOTHER ST. PHILIPPE: Yes, it is our  
8 Order.

9 THE CHAIRMAN: So there is an inter-  
10 relationship between the active hospital and the long-  
11 stay hospital?

12 REVEREND MOTHER ST. PHILIPPE: That is right.

13 THE CHAIRMAN: What do you find in respect  
14 of utilization? Is there any limit on -- for instance,  
15 can you say what percentage ordinarily that the beds  
16 are in use from day to day?

17 REVEREND MOTHER ST. PHILIPPE: I would say  
18 85 per cent to 95 per cent, sometimes 100 per cent;  
19 we have beds out in the hall.

20 THE CHAIRMAN: Do you have a policy ordinarily  
21 that you limit the occupancy?

22 REVEREND MOTHER ST. PHILIPPE: It should be  
23 85 per cent, but we go above that, yes.

24 THE CHAIRMAN: Is that because of --

25 REVEREND MOTHER ST. PHILIPPE: Of the  
26 shortage of space.

27 THE CHAIRMAN: Is that the efficient percentage  
28 of the hospital, 80 per cent, 85 per cent?

29 REVEREND MOTHER ST. PHILIPPE: Yes,  
30 approximately 85 per cent.







1 THE CHAIRMAN: In what circumstances does  
2 this limit pass from when you go up to even 100 per  
3 cent?

4 REVEREND MOTHER ST. PHILIPPE: It is rather  
5 embarrassing; we have to have patients out in the hall  
6 rooms, which is not always good, and it isn't agreeable  
7 for the nurses, it makes it difficult for the nursing  
8 personnel.





1 THE CHAIRMAN: What are the circumstances that  
2 bring that about?

3 REVEREND MOTHER ST. PHILIPPE: Accidents and  
4 medical cases. At this time, during the winter months  
5 particularly, medical cases particularly in winter  
6 months are overcrowded.

7 THE CHAIRMAN: Have you got your figures of  
8 the average stay in hospital?

9 DR. LAURIER: Yes, it is about 12.1 per cent.  
10 I think that is what it was for 1961.

11 REVEREND MOTHER ST. PHILIPPE: Eleven.

12 THE CHAIRMAN: Is that days per patient?

13 DR. LAURIER: Yes, I am sorry.

14 REVEREND MOTHER ST. PHILIPPE: The reason might  
15 be we have a psychiatric department, and they might  
16 remain for sometime. That brings up our average.

17 THE CHAIRMAN: How many psychiatric beds have  
18 you?

19 REVEREND MOTHER ST. PHILIPPE: Thirty-two.  
20 There again we are crowded.

21 THE CHAIRMAN: Are you running pretty well  
22 to capacity?

23 REVEREND MOTHER ST. PHILIPPE: Yes.

24 THE CHAIRMAN: Have you been able to break  
25 those figures down, the length of stay of the psychiatric  
26 patient?

27 REVEREND MOTHER ST. PHILIPPE: We have it, but  
28 we don't have that with us today.

29 DR. LAURIER: It usually runs around 23 days.  
30 It is done monthly, and I do break it down before the







1 Medical Staff Advisory Committee meeting.

2 THE CHAIRMAN: It would have an effect on the  
3 overall figure?

4 DR. LAURIER: Yes, it has definitely.

5 THE CHAIRMAN: What about your maternity length  
6 of stay?

7 REVEREND MOTHER ST. PHILIPPE: Seven days  
8 usually, between five and seven.

9 THE CHAIRMAN: What about shortage of beds?  
10 Have you got a waiting list?

11 DR. LAURIER: Yes, at this time it is roughly  
12 around 600.

13 THE CHAIRMAN: What kind of cases are those?  
14 Are they all elective?

15 DR. LAURIER: No, no. We have three categories,  
16 the immediate admissions and the urgent admissions and  
17 then the elective. Well, this would take care only of  
18 urgent, because we try to admit the emergency cases.  
19 We would have about 350 for medicine and surgery waiting,  
20 and the rest would be psychiatry, paediatrics, neurology,  
21 neuro-surgery and orthopedics.

22 THE CHAIRMAN: How does that compare with the  
23 other hospitals in the Ottawa-Hull area?

24 DR. LAURIER: I guess about the same, I would  
25 imagine, as the other hospitals. I mean, with the  
26 difference in the number of beds of course, but the  
27 average would be about the same, or maybe a little less  
28 than the Civic Hospital.

29 THE CHAIRMAN: Would there be duplication in  
30 connection with some of the cases?





1 DR. LAURIER: Oh, no, no. The ones on our  
2 waiting list, I don't think have been on the waiting  
3 list of the other hospitals.

4 THE CHAIRMAN: Is there any clearing house,  
5 or anything of that kind, which would be able to say  
6 that is so, or how do you know they won't be on the  
7 waiting list of the other hospitals?

8 DR. LAURIER: Well, because our staff is  
9 pretty well closed. Only the doctors attached to our  
10 hospital will treat patients in the General, and it  
11 is about the same thing at the Civic. We might have  
12 a few doctors on our courtesy staff, but they might not  
13 admit more than a few patients a month. We have just  
14 a few of the doctors of the other hospitals on our  
15 courtesy staff, and they do come in very seldom, because  
16 we don't have enough beds. I mean, it has been  
17 increased in the last year. It was not as bad as this  
18 two or three years ago but in the last year, or year  
19 and a half it has been increasing considerably.

20 THE CHAIRMAN: Have you any figures on your  
21 long-stay cases? Have you any long-stay cases to begin  
22 with? I suppose every hospital has?

23 REVEREND MOTHER ST. PHILIPPE: Not very  
24 many, no.

25 DR. LAURIER: At the time you see, we had  
26 submitted a sort of a brief to the City of Ottawa  
27 Entitling Committee in 1960, and at that time --

28 THE CHAIRMAN: Could you have a copy made  
29 available to us?

30 DR. LAURIER: Yes, certainly Mr. Chairman.





1 THE CHAIRMAN: We would be grateful if you  
2 would.

3 DR. LAURIER: And of course it would be  
4 changed now. If we took the time to compare there  
5 would be some changes, because then we said at least  
6 ten per cent of the patients could be discharged to  
7 convalescent hospital care if this was available.

8 THE CHAIRMAN: Does the figure relatively  
9 apply still?

10 DR. LAURIER: About the same.

11 THE CHAIRMAN: You have about fifty patients  
12 you might be able to discharge if there was a convalescent  
13 hospital to which these patients could go?

14 DR. LAURIER: Well you see, it wouldn't mean  
15 ten per cent possibly of adult patients, because we  
16 have about 102 beds in paediatrics, so not too many of  
17 those, although some of them.

18 THE CHAIRMAN: In fact, it might be down to  
19 ten per cent of 400, rather than 500?

20 DR. LAURIER: Yes, and four per cent could be  
21 discharged to care in a chronic disease hospital, and  
22  $2\frac{1}{2}$  per cent could be discharged to custodial care at  
23 that time. Those figures were for 1959.

24 REVEREND MOTHER ST. PHILIPPE: We have more  
25 acute cases, I think, now than we had when this brief  
26 was written.

27 THE CHAIRMAN: You mentioned home care, about  
28  $2\frac{1}{2}$  per cent?

29 DR. LAURIER: Custodial care  $2\frac{1}{2}$  per cent could  
30 be discharged to custodial care.







1 THE CHAIRMAN: Is that the same as home care?

2 DR. LAURIER: No.

3 THE CHAIRMAN: But supposing there was a home  
4 care program available in Ottawa, are there patients  
5 who ordinarily would remain in hospital who might be  
6 discharged?

7 DR. LAURIER: Oh yes, without any doubt,  
8 without any doubt. It would be hard to say the exact  
9 percentage. Miss Simard might have some idea.

10 MISS SIMARD: It is difficult to make  
11 figures when we don't have the resources to know how  
12 many would be eligible, but I think that we both need  
13 custodial care and home care programs. There is a little  
14 bit of custodial care, but not enough for the population  
15 in hospital. I define custodial care, I think, I don't  
16 wish to offer a real definition, but I mean as a  
17 patient who is in need of some nursing care or simple  
18 nursing, routine not complicated care like can be  
19 provided in a chronic hospital. These resources in  
20 this community are very, very limited, and for indigent  
21 and just as much badly needed for private or semi-  
22 private patients. We have very, very little resources  
23 in that area.

24 THE CHAIRMAN: You say you have the situation  
25 of having about 10 per cent of your adult population  
26 who might possibly be discharged if there was  
27 convalescent or chronic accommodation to which they could  
28 go?

29 DR. LAURIER: That is right, yes.

30 THE CHAIRMAN: Is this additional to the





1 accommodation you have available to you at St. Vincent's?

2 DR. LAURIER: Yes, I would imagine so, yes.

3 THE CHAIRMAN: How many beds have you available  
4 at St. Vincent's for the chronic?

5 DR. LAURIER: They have over there 523, but  
6 they are always filled, and the admissions always  
7 exceed the space that they have.

8 MISS SIMARD: St. Vincent's are examining our  
9 requests for admission there very carefully, and some  
10 of them are turned down.

11 THE CHAIRMAN: Where does St. Vincent's get  
12 its 500 from? Is that other hospitals too?

13 REVEREND MOTHER ST. PHILIPPE: Yes, from the  
14 Civic and the City.

15 MISS SIMARD: Just as much as our hospital is  
16 using not only St. Vincent's, but also Perley, which  
17 is a similar hospital, but for English-speaking,  
18 Protestant people. St. Vincent's is providing care for  
19 the Catholic population, but when a patient leaves  
20 either one of the general hospitals, we can make the  
21 application where the patient fits.

22 THE CHAIRMAN: Where the hat fits best?

23 MISS SIMARD: Our hospital is using more St.  
24 Vincent's because our population is more French-speaking  
25 and Catholic, I suppose, than the Civic.

26 THE CHAIRMAN: How many beds are there at  
27 Perley?

28 REVEREND MOTHER ST. PHILIPPE: Under 200, I  
29 believe, I think it is around 200 approximately.

30 DR. LAURIER: We are having a meeting there







1 tomorrow of our Family Welfare Council of Ottawa.

2 SISTER MARIE JOSEPH: They have 218 beds.

3 THE CHAIRMAN: What about an out-patient  
4 department at your hospital?

5 REVEREND MOTHER ST. PHILIPPE: We have an  
6 organized out-patient department, very active, all  
7 services but too small also, the accommodation. We  
8 would need more space, and then many of these patients,  
9 and if we were given more assistance perhaps from the  
10 Commission or the City we perhaps might be able to do  
11 a little more for them, but we have no assistance for  
12 them whatsoever.

13 THE CHAIRMAN: In terms of statistics, how  
14 many patients do you accommodate in the out-patient  
15 department by the week or month, whatever form of  
16 statistical information you may have?

17 REVEREND MOTHER ST. PHILIPPE: We had about  
18 22,000 visits last year. Patients coming to the out-  
19 patient. I think Sister has the exact number, the  
20 report that was sent in to the Commission.

21 SISTER MARIE JOSEPH: 25,768. Now, that is  
22 just --- in the organized out-patient, and 31,398,  
23 that is the organized out-patient.

24 THE CHAIRMAN: What do you mean by the  
25 organized?

26 SISTER MARIE JOSEPH: That is just the clinics.  
27 It does not include emergency. Emergency is 17,718.

28 THE CHAIRMAN: So that we come to about 49,000  
29 altogether?

30 SISTER MARIE JOSEPH: That is right.





1 THE CHAIRMAN: Your emergency and your  
2 organized out-patient --

3 REVEREND MOTHER ST. PHILIPPE: They are  
4 separate.

5 THE CHAIRMAN: Entirely separate?

6 REVEREND MOTHER ST. PHILIPPE: That is right.

7 THE CHAIRMAN: Are they sort of tied together  
8 at all?

9 SISTER MARIE JOSEPH: There is an inter-  
10 relationship in the staff there. When one is too busy  
11 they will take the staff from the other which is not  
12 advantageous.

13 THE CHAIRMAN: Do you operate that seven days  
14 a week?

15 REVEREND MOTHER ST. PHILIPPE: Twenty-four  
16 hours a day.

17 DR. LAURIER: On the emergency. The clinics  
18 themselves would be only about six days a week.

19 THE CHAIRMAN: Six days of twenty-four hours?

20 DR. LAURIER: Yes, well, emergency, not the  
21 clinics, but the clinics would be some in the morning,  
22 because again on account of lack of space we have to  
23 put some in the afternoon, some clinics are held in  
24 the afternoon and some in the morning.





1 THE CHAIRMAN: How are the clinics organized  
2 so far as staffing with physicians?

3 DR. LAURIER: Well, we have, of course,  
4 some resident staff but in medicine, for instance,  
5 there is a geographical full-time man responsible  
6 for the clinic of medicine. He is there most all  
7 mornings to supervise and to do his own clinic himself.  
8 In the surgery department, well, in the department of  
9 general surgery some surgeons are on duty, you know,  
10 every day of the week so one might be there for one  
11 morning.

12 THE CHAIRMAN: Do you follow this session  
13 basis?

14 DR. LAURIER: Yes, for instance, Dr. So and So  
15 will be every Monday morning on duty at the out-patients,  
16 the surgical out-patients.

17 THE CHAIRMAN: And in medicine someone else?

18 DR. LAURIER: That is right, yes -- gynaecology  
19 and paediatrics.

20 THE CHAIRMAN: Are these people paid for  
21 their services?

22 DR. LAURIER: Some of them are. The hospital  
23 is affiliated with the University of Ottawa medical  
24 school so we have what we call geographical full-time.  
25 We have two paid by the university in the Department of  
26 Medicine, we have another one who is full-time but he  
27 is a cardiologist so he gets most of his income from  
28 the hospital, that is, from the interpretation of the  
29 E.K.G.'s.

30 THE CHAIRMAN: Does he get that on a salary







1 basis or a unit basis?

2 DR. LAURIER: Unit basis.

3 COMMISSIONER BALTZAN: Where does that money  
4 come from?

5 DR. LAURIER: From the Ontario Hospitals  
6 Services Commission. In general surgery there is one  
7 now geographical full-time and he will be getting his  
8 office in the hospital in the next few days.  
9 Gynaecology, we will have one coming in in July. In  
10 paediatrics there are two.

11 Of course our heads of departments are paid  
12 by the university and they are considered not  
13 geographical full-time, but considered half-time.  
14 They spend about two full days in the week, for  
15 instance, Tuesdays and Thursdays they will be there all  
16 day but they will be there also every morning.

17 In psychiatry we have four, geographical  
18 full-time. They are paid by the university and by the  
19 Ontario Medical Health Association.

20 THE CHAIRMAN: You have a psychiatric unit in  
21 the out-patient department, in the organized out-patient  
22 department?

23 DR. LAURIER: Yes.

24 THE CHAIRMAN: To what extent is that used?

25 DR. LAURIER: Not as much as we would like to  
26 because unfortunately again the demand is too big. We  
27 cannot give the service because of a lack of doctors  
28 and space.

29 THE CHAIRMAN: You say it exceeds capacity?

30 DR. LAURIER: Definitely.





1 THE CHAIRMAN: Have you any figures on that?

2 DR. LAURIER: There are two, child guidance  
3 which is a very active department where the people have  
4 to wait at least a month for an appointment and then  
5 there is the adult out-patient.

6 SISTER MARIE JOSEPH: In the out-patient  
7 there are about 2800, that is in the out-patient.

8 THE CHAIRMAN: What about child guidance?

9 SISTER MARIE JOSEPH: That includes child  
10 guidance, it is not separate.

11 THE CHAIRMAN: What is it that prevents you  
12 from being able to handle more? Is it just a physical  
13 space proposition or also staff?

14 DR. LAURIER: Staff also -- both, and, of  
15 course, funds because, of course, Ontario funds will  
16 only give so much to so many doctors and no more. We  
17 have right now five on salaries and starting in July  
18 one of them will lose his salary and there will only  
19 be four on salary.

20 THE CHAIRMAN: Why is that? What is the  
21 policy that you are speaking of now where they will  
22 only support the out-patient department by so much?

23 DR. LAURIER: Well, that is the policy of  
24 the Ontario Mental Health.

25 COMMISSIONER McCUTCHEON: That is the  
26 voluntary organization you are talking about, not the  
27 government?

28 DR. LAURIER: Yes, the government, the Ontario  
29 Mental Health grant.

30 COMMISSIONER McCUTCHEON: You said the Mental







1 Health Association.

2 DR. LAURIER: Oh no, the Mental Health  
3 Commission.

4 SISTER MARIE JOSEPH: We receive \$1.50 per  
5 patient for each visit to the clinic which does not  
6 cover the cost. We receive that from the Ontario  
7 Hospital Services Commission.

8 THE CHAIRMAN: That is for these 49000?

9 SISTER MARIE JOSEPH: Anyone coming to the out-  
10 patient clinic we receive \$1.50 per visit.

11 THE CHAIRMAN: Now, a patient comes to the out-  
12 patient clinic, does that patient pay anything himself?

13 SISTER MARIE JOSEPH: Very rarely.

14 THE CHAIRMAN: How is that determined whether  
15 a patient pays or not?

16 SISTER MARIE JOSEPH: There is an assessment  
17 process, I think it is A, B, C, D and E and they are  
18 coded before and that determines if they pay.

19 THE CHAIRMNA: Who does that?

20 SISTER MARIE JOSEPH: There is an admission  
21 officer doing that.

22 THE CHAIRMAN: He belongs to the hospital?

23 SISTER MARIE JOSEPH: Yes, and paid by the  
24 hospital.

25 THE CHAIRMAN: They go to the out-patient and  
26 go by him?

27 SISTER MARIE JOSEPH: That is right.

28 MISS SIMARD: They are generally taking an  
29 appointment before their visit. As much as possible the  
30 out-patient department tries to have patients on an





1 appointment basis so that at the moment they take the  
2 appointment, if they are a new case it is the same place  
3 for grading the admission and the appointment office.

4 THE CHAIRMAN: What about in the emergency  
5 section?

6 SISTER MARIE JOSPEH: They have a clerk in  
7 the section who takes all the information necessary and  
8 if they become a clinic patient they are transferred  
9 over there.

10 MISS SIMARD: I would like to point out about  
11 the lack of funds that the \$1.50, of course, covers a  
12 very little of the medication. I think this Commission  
13 will probably be informed about this difficulty about  
14 drugs but I think this is one of the difficulties to  
15 give drugs to indigent patients. This is certainly  
16 something where there is very often lack of availability  
17 of funds to cover the out-patients. You will be hearing  
18 about this tomorrow --

19 THE CHAIRMAN: You say we will be hearing about  
20 this tomorrow?

21 MISS SIMARD: Yes, I will be coming back  
22 tomorrow and I know we will present cases. You will  
23 hear about it tomorrow but it is the same problem here  
24 in the process of operating an out-patient department  
25 with so little funds available the drug problem is  
26 stemming out of it.

27 DR. LAURIER: The biggest problem I think we  
28 realize is that we have a big debt, as a matter of fact  
29 it is \$7 million and we have an interest charge of  
30 \$315,000.00. We have started receiving from the







1 Ontario government \$315,000.00 which is supposed to be  
2 given every year for twenty years and this is to help  
3 us pay our debt. Well, we can with this pay it but  
4 we cannot buy equipment, we cannot increase the number  
5 of our beds, we cannot save any space for research  
6 because of lack of funds. You see, the City of Ottawa  
7 is not helping our hospital, our hospital has never  
8 made a drive in the 115 years that it has been in  
9 Ottawa and it has never received a cent of help from the  
10 City of Ottawa. We are in very bad need of space for  
11 research. We cannot get top notch men in the hospital  
12 and the medical school because we do not have space  
13 for research. It is very hard, also, to get Canadian  
14 interns again because they would rather go to a place  
15 where they have all the facilities and all the equipment  
16 needed. Right now, if we had, for instance, 200 more  
17 beds it would only take part of our waiting list. We  
18 need also more space for operating rooms for the  
19 emergency department, for the out-patient department  
20 and there is nothing we can do and we cannot progress  
21 on account of that. This is a real big problem.

22 THE CHAIRMAN: Dealing with your operating  
23 rooms, is it the custom that you use them only certain  
24 parts of the day or are they used over what period?

25 REVEREND MOTHER ST. PHILIPPE: The whole  
26 day long and emergencies at night.

27 DR. LAURIER: The program usually goes on  
28 until about 3:00 o'clock so usually no cases, except  
29 emergency cases, are done after 4:00 o'clock and on  
30 Saturday mornings only emergency cases are done, no







1 elective surgery is done Saturday mornings because  
2 we cannot get the personnel to work weekends with the  
3 forty hour week.

4 THE CHAIRMAN: How many operating room shifts  
5 do you use now?

6 DR. LAURIER: Well, there are three in the  
7 sense that there is always one shift for emergency at  
8 night or on call in the daytime. Some start at  
9 different hours so they can go on a little later in the  
10 afternoon.

11 THE CHAIRMAN: Is there more than one section  
12 working at a time?

13 REVEREND MOTHER ST. PHILIPPE: During the day  
14 all the operating rooms very often are in use at the one  
15 time.

16 THE CHAIRMAN: A period of eight hours?

17 REVEREND MOTHER ST. PHILIPPE: That is right --  
18 I would not say eight hours, I would say six hours.

19 THE CHAIRMAN: So you just have the one shift  
20 in that sense?

21 REVEREND MOTHER ST. PHILIPPE: Yes, because  
22 they have to have time to prepare for the next day and  
23 it takes a little time to prepare the operating room  
24 for the operating day.

25 DR. LAURIER: We only have the one group.

26 REVEREND MOTHER ST. PHILIPPE: Yes, they are  
27 on call.

28 COMMISSIONER BALTZAN: Please remember that  
29 anything I may ask that has already been asked and  
30 answered please say so because the accoustics are bad





1 here and I have not been able to get all the answers.

2 DR. LAURIER: I am sorry.

3 COMMISSIONER BALTZAN: Would you please tell  
4 me with the money you collect or from the little fees  
5 you get from the out-patient department or any  
6 psychiatry, is that added to your budget or subtracted  
7 from your budget?

8 SISTER MARIE JOSEPH: That is subtracted in  
9 the budget, that is deducted in the budget.

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1 COMMISSIONER BALTZAN: So you have no  
2 spares?

3 SISTER MARIE JOSEPH: No spares whatso-  
4 ever.

5 COMMISSIONER BALTZAN: That is what I  
6 wanted to know. The next question: since the advent of  
7 this Ontario Hospital National Scheme do you find that  
8 your admissions to the hospital have increased noticeably?

9 SISTER MARIE JOSEPH: They have increased,  
10 yes.

11 COMMISSIONER BALTZAN: Can you tell me  
12 whether the length of stay for a patient compared to  
13 previously has also increased?

14 SISTER MARIE JOSEPH: No. That has  
15 come down I think.

16 DR. LAURIER: This would have decreased.  
17 I must add something here, sir: before the Hospital  
18 Insurance Scheme in Ontario we used to be getting a  
19 good number of patients from the Province of Quebec and  
20 of course when the Hospital Insurance Scheme started in  
21 1959 in Ontario, they did not have it in Quebec; we  
22 accepted much less people from Quebec because at the  
23 time those who could pay, we could accept, but those  
24 who could not pay, we could not accept because it would  
25 have been a loss, you see, to the hospital.

26 COMMISSIONER BALTZAN: Your people in  
27 the out-patient department - your doctors are geographical,  
28 part-time and full-time and who pays them?

29 DR. LAURIER: The University.

30 COMMISSIONER BALTZAN: Would you please





1 tell me what provision have you for semi-private beds  
2 and private beds? Roughly. May I make it very easy  
3 for you? Have you enough or not enough?

4 SISTER MARIE JOSEPH: I can give you  
5 both semi-private and private together: 272. Now, in  
6 that there are 88 private beds. 184 semi-private;  
7 standard ward, 349. Those are beds set up at December  
8 31st, not the rated bed capacity. The report asks us  
9 the rated bed set-up. There are two capacities and  
10 this is the bed set-up.

11 COMMISSIONER BALTZAN: You find that  
12 you have demand for more semi-private and more private  
13 if you had the accommodation?

14 SISTER MARIE JOSEPH: Perhaps more  
15 semi-private, yes. And then wards also. In view of  
16 the fact that the Commission, the plan is for standard  
17 ward accommodation, many people have the preferred but  
18 the majority just have ward accommodation.

19 COMMISSIONER BALTZAN: They only take  
20 that because you cannot supply them with that which they  
21 prefer?

22 SISTER MARIE JOSEPH: That is right.  
23 In many instances they will ask for ward accommodation.  
24 We do not have it. We have to put them in semi-private  
25 rooms.

26 COMMISSIONER BALTZAN: If you had that  
27 extra accommodation, it would be useful to the people  
28 but also it would be of benefit to your own operation?

29 SISTER MARIE JOSEPH: That is right.

30 COMMISSIONER BALTZAN: Why don't you







1 get it?

2 SISTER MARIE JOSEPH: We don't have the  
3 funds to build.

4 COMMISSIONER BALTZAN: Maybe I haven't  
5 the right to ask that question.

6 DR. LAURIER: Because we do not have  
7 the funds. That is our big problem.

8 COMMISSIONER BALTZAN: If you had the  
9 funds would you be allowed to go ahead and do it?

10 DR. LAURIER: That is right.

11 THE CHAIRMAN: What becomes of the  
12 revenue from the private and semi-private accommodation?

13 SISTER MARIE JOSEPH: We are allowed to  
14 keep 50% of that which we have to apply on our debt and  
15 then in some instances there are also non-allowable  
16 costs which the Commission does not accept and this  
17 also has to come out of our differential and very often  
18 the depreciation which they allow on equipment does not  
19 suffice to give us the funds we need to purchase equipment,  
20 so it is necessary we try and use some of the differential  
21 but we have to keep most of it for the debt because we  
22 cannot meet this 500,000.

23 We are still lacking 185,000 a year to  
24 meet our payment on the debt. The Commission has given  
25 us 315 but we have about 500,000 to meet per year on the  
26 debt.

27 THE CHAIRMAN: You get the difference  
28 between 315 and the 500,000 and some odd, you get from  
29 the private and semi-private accommodation?

30 SISTER MARIE JOSEPH: We have to use







1 some of that, yes.

2 COMMISSIONER BALTZAN: Is it fair to  
3 say then what looks like on the books as a profit is  
4 only less than half a profit?

5 REV. MOTHER STE. PHILIPPE: That is  
6 right.

7 COMMISSIONER BALTZAN: You can only  
8 count on just that much of the surplus, not what it  
9 looks like on the books?

10 SISTER MARIE JOSEPH: I wasn't following  
11 you there, sir.

12 COMMISSIONER BALTZAN: Maybe I wasn't  
13 following you. You say that you only are allowed 50%  
14 whereas the other 50% is taken away. You have not got  
15 the full benefit of the differential?

16 SISTER MARIE JOSEPH: No. We have only  
17 the benefit of the 50% and whether it is collected or  
18 not. Many a time it is not and in completing the budget  
19 50% of the estimated differential is deducted immediately  
20 in determining the per diem rate.

21 COMMISSIONER BALTZAN: Whether you  
22 have got it or not?

23 SISTER MARIE JOSEPH: Whether we have  
24 it or not.

25 COMMISSIONER BALTZAN: That is what I  
26 wanted to get. Thank you. May I carry on, Mr. Chairman,  
27 for a minute or two? I have already heard that a good  
28 number of your Quebec people are not able to come over  
29 for the reasons that you have stated, but you have been  
30 up until then receiving a lot of non-city residents as





1 referred patients from outlying areas?

2 REV. MOTHER STE. PHILIPPE: Yes.

3 COMMISSIONER BALTZAN: That has been  
4 substantially reduced because of this condition?

5 DR. LAURIER: Now, of course, since  
6 Quebec has entered into the scheme we do accept Quebec  
7 people and we do still accept a few in our out-patient  
8 department, although we are not getting anything at all  
9 for them, but we still accept - I would not be able to  
10 give you figures, unfortunately, but we still accept  
11 some from Quebec.

12 We also get some from the surrounding  
13 cities or places in Ontario.

14 COMMISSIONER BALTZAN: Are you a univer-  
15 sity hospital here or an affiliated teaching hospital?

16 DR. LAURIER: It is affiliated but it  
17 has been the first hospital that has been affiliated with  
18 the medical school. It was the only one until two or  
19 three years ago when the Civic Hospital was affiliated  
20 with medical school but until that time our hospital  
21 was ---

22 COMMISSIONER BALTZAN: You are still  
23 the first?

24 DR. LAURIER: Yes.

25 COMMISSIONER BALTZAN: How are you or  
26 the supply of interns in your hospital?

27 DR. LAURIER: Very bad for Canadian  
28 interns. The majority of our interns or residents are  
29 foreigners from some 18 countries and it is very hard  
30 for us to attract Canadian interns for many reasons, of







1 course.

2 COMMISSIONER BALTZAN: Are all your  
3 departments - this is not a quiz - I am just trying to  
4 get the information. Are all your departments recognized  
5 by the Royal College of Physicians?

6 DR. LAURIER: Except otolaryngology.  
7 There has been a request to be approved. We have had no  
8 answer yet.

9 Another department is the Department of  
10 Neurology and Neurosurgery because the Royal College felt  
11 that we did not have sufficient number of patients to  
12 have somebody in training.

13 While we do not agree there, they have  
14 the last word.

15 COMMISSIONER BALTZAN: One other point.  
16 You may answer it if you like and that is: do the  
17 teachers in your hospital find much difficulty in using  
18 what we will call the clinical material for teaching  
19 purposes in your hospital?

20 DR. LAURIER: By "difficulty" you mean ---?

21 COMMISSIONER BALTZAN: Do patients  
22 resent now or object to - do the students get enough  
23 opportunity to examine or have clinics of patients?

24 DR. LAURIER: Of course, they had more  
25 cases before the Hospital Insurance Scheme because at  
26 that time, since there was no insurance scheme, you had  
27 people coming, for instance, to the wards because it was  
28 much cheaper and they are going to the out-patient depart-  
29 ment.

30 I am pretty sure this has diminished





1 when the Hospital Insurance Scheme came into effect but  
2 we cannot say that it is a problem in our hospital at  
3 the time being; that it is a big problem for the medical  
4 students.

5 COMMISSIONER BALTZAN: That is all I  
6 wanted.

7 DR. LAURIER: It is not a big problem.

8 COMMISSIONER BALTZAN: It is not  
9 noticed?

10 MISS SIMARD: On the contrary - could I  
11 say so because I am actively involved, working on the  
12 wards and I am also teaching the medical students with  
2 13 the Department of Preventive Medicine and I have always  
14 been impressed to see how, in this hospital, the medical  
15 students are looked up to by the patients and very often  
16 they refer to them as doctors and I have seen some asking  
17 for that medical student instead of the head man because  
18 he was - I just mean that the relationship, I do not  
19 think this is a problem for the time being from what I  
20 have observed.

21 COMMISSIONER BALTZAN: I wish you were  
22 here a few days ago.

23 DR. LAURIER: We read that.

24 COMMISSIONER BALTZAN: I am just  
25 finished now. You referred here to the St. Vincent's  
26 Hospital. That is for the chronically ill?

27 REV. MOTHER STE. PHILIPPE: That is  
28 right.

29 COMMISSIONER BALTZAN: It is not for  
30 domiciliary cases?





1 DR. LAURIER: No.

2 COMMISSIONER BALTZAN: You liberate  
3 your active beds, is that the idea of the St. Vincent's  
4 Hospital?

5 DR. LAURIER: That is a long-stay  
6 hospital.

7 COMMISSIONER BALTZAN: That is my  
8 final question. You anticipated it. Have you any idea  
9 of the average length of stay for, say, all cases in  
10 this hospital? Don't answer it. Some time I hope we  
11 can get it from you. Thank you very much.

12 COMMISSIONER GIRARD: What is the  
13 percentage of public beds that the Ontario Hospital  
14 Insurance wants you to keep in relation to the total  
15 beds?

16 REV. MOTHER STE. PHILIPPE: 50%.

17 COMMISSIONER GIRARD: And what is your  
18 percentage of depreciation? How much do they allow?  
19 What percent of depreciation do they allow?

20 SISTER MARIE JOSEPH: Depreciation on ---?

21 COMMISSIONER GIRARD: On equipment.

22 SISTER MARIE JOSEPH: On equipment we  
23 have to follow the check list of CHAN. We set up a plan  
24 ledger and each piece of equipment that is purchased has  
25 a life in years.

26 COMMISSIONER GIRARD: How many years is  
27 this life? I just want to compare it with Quebec.

28 SISTER MARIE JOSEPH: It is not the  
29 same with Quebec because in Quebec you have, I think,  
30 15 or 16 years? 16 years. That is, supposing I buy a







1 piece of equipment which, according to CHAN, has a life  
2 of 10 years, I will depreciate it over the period of  
3 time of 10 years.

4 COMMISSIONER GIRARD: It is individual  
5 equipment?

6 SISTER MARIE JOSEPH: Individual equip-  
7 ment.

8 COMMISSIONER VAN WART: Broadly  
9 speaking, since the coming in of the Hospital Plan, has  
10 it been easier for you to replace equipment than formerly?

11 SISTER MARIE JOSEPH: Well, now that  
12 depends. You take some will ask for equipment costing  
13 up around \$20-\$30,000. It has been very difficult. We  
14 just cannot afford it because our yearly depreciation  
15 does not meet those amounts and if we do that, we are  
16 depriving others of some smaller equipment, perhaps of  
17 smaller value, which they need so if we give this  
18 person, say, \$30-\$50,000 in equipment which they need,  
19 we deprive the others. We do not have the funds.

20 THE CHAIRMAN: Is it different from  
21 before?

22 COMMISSIONER VAN WART: Is it different  
23 from before the Hospital Plan came in?

24 SISTER MARIE JOSEPH: Yes.

25 COMMISSIONER VAN WART: It's easier  
26 now or formerly?

27 SISTER MARIE JOSEPH: I think it was  
28 formerly easier as far as equipment although we weren't  
29 able to fund depreciation which we are doing now,  
30 which is an advantage, because most hospitals did not do it.





1 COMMISSIONER VAN WART: In other words, you  
2 are finding it harder now to replace equipment?

3 SISTER MARIE JOSEPH: We are finding it  
4 harder because the amount of money was limited, whereas  
5 prior to that, some years we had money and some years  
6 we hadn't enough, but it is true to say that since the  
7 plan operation has been easier, that is operating costs,  
8 although full costs are not acceptable.

9 COMMISSIONER VAN WART: Has your hospital  
10 been running at a deficit since the plan?

11 SISTER MARIE JOSEPH: Yes, we are running at  
12 a deficit.

13 COMMISSIONER VAN WART: A larger deficit  
14 than before?

15 SISTER MARIE JOSEPH: Just about the same,  
16 because it includes the debts, building depreciation,  
17 non-allowable costs. So it runs about the same thing.

18 COMMISSIONER VAN WART: So the plan has not  
19 affected you in that respect?

20 SISTER MARIE JOSEPH: Not too much.

21 THE CHAIRMAN: How many Sisters do you have  
22 on the staff of the hospital?

23 SISTER MARIE JOSEPH: We have about 39, 40  
24 Sisters working on the staff.

25 REVEREND MOTHER PHILIPPE: We have over 1100  
26 personnel.

27 SISTER MARIE JOSEPH: We are grateful to the  
28 Commission, but we feel they have taken some things  
29 away from us. We can't operate as we did in the past  
30 and things are tight.







1 THE CHAIRMAN: There are certain regulations  
2 with which you have to abide?

3 SISTER MARIE JOSEPH: Yes.

4 THE CHAIRMAN: With 1100 personnel you are not  
5 out of line with over 600 beds.

6 SISTER MARIE JOSEPH: No. We have no way  
7 of extension because we have no funds, we have no means  
8 of getting it.

9 DR. LAURIER: Apparently Ottawa is the only  
10 city in Ontario where the corporation of the city does  
11 not help proprietary hospitals. Hospitals in Toronto  
12 like St. Joseph's and St. Michael's have been helped,  
13 the same in Windsor and Hamilton.

14 THE CHAIRMAN: You have a special problem here.

15 REVEREND MOTHER ST. PHILIPPE: Yes.

16 SISTER MARIE JOSEPH: Yes. We have never  
17 received any assistance from the Corporation of Ottawa.

18 COMMISSIONER VAN WART: No assistance?

19 SISTER MARIE JOSEPH: Never. We have always  
20 carried the burden, and that has been the trouble; we  
21 have no means of carrying it.

22 THE CHAIRMAN: Thank you very much Reverend  
23 Mother St. Philippe, Miss Simard. This is the type of  
24 information that is very helpful to us in seeing the  
25 day to day workings of a hospital the size of yours,  
26 which is a large hospital, and seeing the picture, the  
27 overall picture throughout Canada. We are grateful to  
28 you for having accepted the occasion to come and give  
29 this information.

30 REVEREND MOTHER ST. PHILIPPE: We have enjoyed





1 it, thank you.

2 DR. LAURIER: If we have helped you we hope  
3 you can help us too.

4 MR. HALL: Mr. Chairman, in response to the  
5 same type of letter, there are present from the St.  
6 Louis Marie de Montfort Hospital the Administrator,  
7 Reverend Sister Beatrice de L'Immaculée, the Assistant  
8 Administrator, Sister Rita, and the Medical Director,  
9 Dr. W.F. Cormier.

10 I believe they were present at the last  
11 discussion, so they pretty well all know the position  
12 and the information desired.

13  
14 SUBMISSION OF ST. LOUIS MARIE DE MONTFORT  
HOSPITAL

15 APPEARANCES:

16 Reverend Sister Beatrice de L'Immaculée  
17 Sister Rita  
18 Dr. W.F. Cormier

19 THE CHAIRMAN: Who is going to be the spokesman?  
20 Dr. Cormier?

21 DR. CORMIER: Yes, I could start, and if I have  
22 to rest in some corner I may have to ask the Sisters  
23 to answer.

24 THE CHAIRMAN: Were you present throughout  
25 the discussion we were having with the Sisters who have  
26 just left from the Ottawa General Hospital?

27 DR. CORMIER: Yes, but I am hard of hearing  
28 and I could not get it all.

29 THE CHAIRMAN: I thought we might be able to  
30 shorten it up a bit by asking your position. You have







1 pretty well the same situation as the Ottawa General  
2 Hospital. Now, what is the size of your hospital, how  
3 many beds?

4 REVEREND SISTER BEATRICE de L'IMMACULÉE: We  
5 have 227.

6 THE CHAIRMAN: You are in a different category.

7 REVEREND SISTER BEATRICE de L'IMMACULÉE: Yes.

8 DR. CORMIER: Excuse me, are you referring  
9 there to basinettes, Mother Superior?

10 REVEREND SISTER BEATRICE de L'IMMACULÉE:  
11 Plus basinettes.

12 THE CHAIRMAN: How does your patient stay  
13 compare with the Ottawa General?

14 REVEREND SISTER BEATRICE de L'IMMACULÉE: It is  
15 8.2.

16 THE CHAIRMAN: Do you have a psychiatric  
17 department or any psychiatric beds?

18 REVEREND SISTER BEATRICE de L'IMMACULÉE: No,  
19 we don't have any of these.

20 THE CHAIRMAN: And your maternity stays?

21 SISTER RITA: Six.

22 DR. CORMIER: Not quite six, 5. -- between  
23 five and six.

24 THE CHAIRMAN: Do you have patients in the  
25 hospital who might be somewhere else, in a convalescent  
26 home or in a chronic hospital?

27 DR. CORMIER: We surely have, and it is a  
28 daily headache.

29 THE CHAIRMAN: And what proportion of your  
30 population?







1 DR. CORMIER: It is hard to say, because it  
2 is moving there every day or every week, because  
3 sometimes we can have someone on the waiting list  
4 for St. Vincent's, three or four, and if they have  
5 openings we may go down to one or zero, and two or  
6 three days afterwards we build up with other cases, and  
7 some have to wait so long they give up hope and they  
8 leave us for good before we can transfer them to a  
9 chronic hospital.

10 THE CHAIRMAN: I suppose you have access to  
11 patients --

12 DR. CORMIER: Yes. As a matter of fact, the  
13 great majority of our patients are French and Catholics.

14 THE CHAIRMAN: To begin with.

15 DR. CORMIER: Yes. And we had three or four  
16 cases that we referred to the Perley Home, but with  
17 the same results, we had to take their names, wait for  
18 a requisition and wait a long, long time.

19 THE CHAIRMAN: What about out-patients?

20 REVEREND SISTER BEATRICE de L'IMMACULÉE: We  
21 have no facilities for out-patients; we just have  
22 emergency.

23 THE CHAIRMAN: To what extent is that used?

24 DR. CORMIER: Although we do not have an  
25 out-patient department there is more than half of the  
26 patients coming out there for treatment which are not  
27 emergency cases, so we have to take care of them just the  
28 same; and even if it is more work it is much less money,  
29 too, because they come over there having in mind -- there  
30 is lots of education to be done -- they have in mind,





1 most of them, that coming there they have free medical  
2 services because the hospital is paying medical doctors  
3 to take care of the patients at the emergency or the  
4 out clinic, and they come over there not to just go  
5 to the doctor's office, to not receive any bill. Most  
6 of them have in mind not to pay the hospital and we  
7 have to take care of everything.

8 THE CHAIRMAN: I take it your hospital is  
9 not located in the central part of the city?

10 DR. CORMIER: No, it is in the eastern part.  
11 But since, I would say, the last five years there is  
12 a new area opening up, lots of building and the  
13 population is expanding and growing that way; not so  
14 much as the west end but it does grow up fast, too.

15 THE CHAIRMAN: How many miles east of this  
16 location here, from the Chateau?

17 DR. CORMIER: Not much more than three miles;  
18 perhaps less than three miles.

19 THE CHAIRMAN: And I take it you are not part  
20 of the teaching hospital?

21 DR. CORMIER: We are, sir, yes, because  
22 unofficially we have been teaching there in the  
23 Department of Obstetrics since over three or four  
24 years. But officially we are affiliated to the  
25 Faculty of Medicine in Ottawa since 1961, so lately we  
26 will have in most of our departments from September  
27 next medical students; how many we don't know, that  
28 depends. Well, now with the Royal San the mental unit  
29 is affiliated to, and we don't know, it depends on the  
30 number of students, and we have to keep that balance.







1 But now we have one or two in obstetrics and one in  
2 pathology.

3 THE CHAIRMAN: What about use of the hospital  
4 for diagnostic services? Do you find any use being  
5 made for diagnostic services rather than for other  
6 facilities, facilities needed for the hospitalized  
7 patients, patients who should be hospitalized?

8 DR. CORMIER: Well, in my humble opinion, if  
9 patients were covered by somebody --

10 THE CHAIRMAN: By the hospitalization plan?

11 DR. CORMIER: Yes -- I am sure that the  
12 waiting list in hospitals would decrease.

13 THE CHAIRMAN: That is waiting lists. What  
14 about population in the hospital?

15 DR. CORMIER: Actually in, percentage of  
16 occupation?

17 THE CHAIRMAN: No, would there be fewer  
18 people actually go into the hospital?

19 DR. CORMIER: I think so, sir, because the  
20 thing is this: medical doctors are honest but the  
21 patients these days are quite well informed and quite  
22 tricky, and if they go to one doctor and he says he  
23 can't take him, that is just for a diagnosis, that is  
24 not covered and you have to go to an out-patient  
25 and pay \$20.00 or \$25.00 for x-ray or something like  
26 that, and so the patient walks outs and he tries  
27 somebody else. But he will finally find a doctor,  
28 and reading all the magazines he knows something about  
29 medicine and he puts on a show, subjective symptoms,  
30 and a doctor in good faith will make a requisition for





1 that chap, and he will get what he is looking for and  
2 then their cost is much more than if we have the  
3 possibility of sending him for a checkup and, if necessary,  
4 to admit him.

5 THE CHAIRMAN: Do you have facilities for an  
6 out-patient department if these services were required?

7 DR. CORMIER: There are at least lands and  
8 we could do something. But like any other hospitals  
9 we are short in space, we would need more space for  
10 the lab, for the x-ray department. We have a school  
11 of nursing without a school. If we could have --

12 THE CHAIRMAN: What do you mean a school of  
13 nursing without a school?

14 DR. CORMIER: Well, without a building, sir,  
15 and we have no quarters for the interns. So you see  
16 it is a problem. There now is the worst spot; where  
17 the waiting list is the longer it is in more active  
18 problems, it is in medicine.

19 THE CHAIRMAN: How do you operate the school  
20 of nursing without a building? Do you have a  
21 residence?

22 DR. CORMIER: Yes. Well, we have to do the  
23 best we can, and surely it would be better for them  
24 too, because they have to travel too much and they  
25 would be more happier, and us, if we could see a  
26 building going up and we would have to look forward  
27 for a decent place to teach, have a hall of medical  
28 art or something like that.

29 THE CHAIRMAN: Are there any home care programs  
30 operating out of the hospital?





1 REVEREND SISTER BEATRICE de L'IMMACULÉE: No.

2 DR. CORMIER: Well, they are now in Ottawa;  
3 with the whole planning committee we have lots of  
4 services going on and documentation put together,  
5 and we are looking forward to that. I think there  
6 is lots of education to be done first of all, and we  
7 feel with time that it will bring some relief.







1 It is hard. People change. A few  
2 years ago people were taking care of their old folks.  
3 Today, if they come to the hospital with something acute  
4 like pneumonia or an attack of appendicitis, or something  
5 like that, they come to the hospital and after 8 or 10  
6 or 14 days when they are ready to go home we call.  
7 Well then, the picture all changes in the family. "I am  
8 sick. We cannot take grandpere, and I have no money",  
9 so we are caught with grandpere, so we keep him.

10 COMMISSIONER McCUTCHEON: I take it  
11 from the way you put it that that is more a change in  
12 attitude than in facts?

13 DR. CORMIER: Well, I think they depend  
14 on somebody else too much today.

15 COMMISSIONER McCUTCHEON: That is what  
16 I meant.

17 DR. CORMIER: Yes, and even some cases  
18 I work on and talk to them, and finally I get results and  
19 they take their aged folks back home, because I make  
20 them understand they should keep on carrying their respon-  
21 sibilities, and not depend on somebody else too much,  
22 but that problem exists, and very, very, very often,  
23 even for children.

24 THE CHAIRMAN: Besides going back home,  
25 are there homes for the aged, where these people might  
26 be able to go?

27 DR. CORMIER: Well, there is some  
28 resort, but really I don't think there is enough there  
29 now in Ottawa. There are lots of studying going on, and  
30 even in Eastview, because as you know, Eastview is in the





1 centre of Ottawa, and it is a municipality by itself.

2 THE CHAIRMAN: It is surrounded?

3 DR. CORMIER: Yes, Eastview has no  
4 hospital, although they call their hospital, St. Louis  
5 Marie de Montfort, they call the Eastview Hospital.

6 THE CHAIRMAN: But it is not in the  
7 Eastview municipality?

8 DR. CORMIER: No, it is not now sir,  
9 and they have no home for the old-aged people. They  
10 hardly have anything. It is just since recently that  
11 they have the Health Board, and we are working on it  
12 there now, but we have lots of work to do, and as every-  
13 where, to do something we need debt, but we don't get any.

14 COMMISSIONER VAN WART: Do you get any  
15 financial help from Eastview?

16 DR. CORMIER: For the hospital sir?

17 COMMISSIONER VAN WART: Yes.

18 DR. CORMIER: No, nor from Ottawa, and  
19 still it is amazing like today I was called up to try to  
20 help a chap about 24, 25, single, born and living in  
21 Ottawa, who needed complete teeth extraction because he  
22 had bad tooth decay with awful bad gums. I am sure his  
23 kidneys are now suffering from it. He was not working,  
24 but was expecting insurance, but he won't be covered  
25 till three months. He had to turn the forms into Toronto.

26 THE CHAIRMAN: It is three months to be  
27 covered for hospitalization?

28 DR. CORMIER: Yes, after they turn in  
29 the application. The same thing as Quebec, so he won't  
30 be covered. I thought it was simple. I would get a







1 medical doctor and an anaesthetist to do the work for  
2 nothing, and a dentist to do the work for nothing, so  
3 now I have the problem he does not have the insurance.

4 THE CHAIRMAN: Well, I suppose you have  
5 to do it anyway?

6 DR. CORMIER: Oh yes, no doubt.

7 COMMISSIONER VAN WART: He had attention  
8 under the old system?

9 DR. CORMIER: Yes, well, sometimes they  
10 are fixed, they haven't got much, but too much to have  
11 some support, some help.

12 THE CHAIRMAN: Thank you very much,  
13 Dr. Cormier, and Reverend Sisters. As I told the others,  
14 this information on the operation of the day-to-day opera-  
15 tion of these hospitals, and your hospital represents  
16 another category. It is in not a small hospital, but it  
17 is in the smaller range, and we have to see just how it  
18 is working out in terms of the Dominion/Provincial  
19 Hospital Scheme, and whether anything has to be done to  
20 make it work better.

21 We didn't discuss your financial  
22 situation, but I suppose you are getting by some way?

23 SISTER BEATRICE de L'IMMACULEE: We are  
24 in about the same situation as the Sisters in the Ottawa  
25 General, on a smaller scale.

26 THE CHAIRMAN: You have a few private  
27 and semi-private beds, I suppose?

28 SISTER BEATRICE de L'IMMACULEE: Yes.

29 THE CHAIRMAN: And you get 50% there?

30 SISTER BEATRICE de L'IMMACULEE: We





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1 have 50% in our private wards.

2 THE CHAIRMAN: And do you get a grant  
3 from the province to apply towards the interest payment  
4 as well?

5 SISTER BEATRICE de L'IMMACULEE: Yes,  
6 80,000 dollars.

7 THE CHAIRMAN: That is on the basis of  
8 your financial situation?

9 SISTER BEATRICE de L'IMMACULEE: Yes.

10 DR. CORMIER: It would be very interesting  
11 in talking about the interns, because still our situation  
12 is darker than the one that does exist in the General or  
13 the Ottawa Civic.

14 THE CHAIRMAN: You may have difficulty  
15 there?

16 DR. CORMIER: Yes.

17 THE CHAIRMAN: Where do you hope to  
18 recruit interns?

19 DR. CORMIER: Well, there is a Canadian  
20 university right in our town here. We would look toward  
21 the university, but what happens is in the United States  
22 they are offering them much more money than we can give  
23 them. It is not an account of program so much. They  
24 are all married, most of them, and having responsibilities,  
25 that they go where it pays more.

26 THE CHAIRMAN: And they actually go from  
27 Ottawa? How many students are graduated from Ottawa  
28 University in medicine in a year?

29 DR. CORMIER: Well, I would think  
30 around 50, 45, 50, or it could be a little bit more or a





1 little less.

2 THE CHAIRMAN: Do many of those stay in  
3 Ottawa and do their intern?

4 DR. CORMIER: I think there is one in  
5 the General and two in my hospital, and that is three,  
6 and there may be one in the Civic.

7 THE CHAIRMAN: You don't do very well?

8 DR. CORMIER: Oh yes, we do very, very  
9 well, because otherwise we would not have any at all.

10 THE CHAIRMAN: I mean to say, out of 50?

11 DR. CORMIER: Yes.

12 THE CHAIRMAN: Well, thank you very  
13 much, and we are grateful to you for having come and  
14 been of help to us.

15 We shall recess until 10 o'clock tomorrow  
16 morning.

17  
18 --- Adjournment.

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